California Western Law Review

Volume 54 | Number 1 Article 13

7-1-2018

IS THIS HOSPITAL CATHOLIC? ASSESSING THE LEGALITY OF MERGER CONTRACTS THAT DEMAND ADHERENCE TO RELIGIOUS DOCTRINE

Brooke Raunig

COMMENT

IS THIS HOSPITAL CATHOLIC? ASSESSING THE LEGALITY OF MERGER CONTRACTS THAT DEMAND ADHERENCE TO RELIGIOUS DOCTRINE

TABLE OF CONTENTS

I. INTRODUCTION

Just outside of Chicago, a young woman sought treatment from a Catholic hospital.[1] She was pregnant and her water had broken prematurely.[2] Unfortunately, she was carrying a nonviable fetus that held no chance of survival.[3] The situation was urgent, and the hospital should have induced labor to prevent the risk of infection or death.[4] Instead, due to the presence of a fetal heartbeat, the hospital refused to adhere to acceptable medical standards of care,[5] and the young woman developed an infection.[6] After ten days she was "dying of sepsis."[7] By the time she was transferred to another facility her fever had reached 106 degrees.[8] Dr. David Eisenberg sat with her in the hospital's Intensive Care Unit, fearing for her life and describing her as "the sickest patient [he had] ever cared for during [his] residency."[9] Along with cognitive injuries, the sepsis damaged one of the woman's kidneys

1. JULIA KAYE ET AL., HEALTH CARE DENIED 12 (2016).
2. *Id.*
3. *Id.*
4. *Id.*
5. *See id.* (Dr. David Eisenberg explained that in situations like this, expediting delivery is always "the right thing to do," and that the facility he was at "would never wait that long to evacuate the uterus."); *see also* Aaron B. Caughey et al., *Contemporary Diagnosis and Management of Preterm Premature Rupture of Membranes*, 1 REVS. IN OBSTETRICS & GYNECOLOGY 1, 16 (2008); Thaddeus P. Waters & Brian M. Mercer, *The Management of Preterm Premature Rupture of Membranes Near the Limit of Fetal Viability*, 201 AM. J. OBSTETRICS & GYNECOLOGY 230, 237–38 (2009); Am. Coll. of Obstetricians & Gynecologists, *ACOG Practice Bulletin No. 172: Premature Rupture of Membranes*, 128 OBSTETRICS & GYNECOLOGY e165, e171 (2016) [hereinafter *Practice Bulletin No. 172*] (explaining that "[i]mmediate delivery should be offered" when PROM occurs prior to neonatal viability).
6. KAYE ET AL., *supra* note 1, at 12.
7. *Id.* Sepsis is a serious and potentially life-threatening complication that develops from an infection. To fight the infection, the body releases chemicals into the bloodstream that elicit an inflammatory response. However, this inflammatory response can turn deadly when, instead of fighting the infection itself, it "trigger[s] a cascade of changes that damage multiple organ systems, causing them to fail." *Sepsis*, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214 (last visited May 11, 2018).
8. *Id.*
9. *Id.*

to a point that required dialysis to keep it from failing, and she was eventually transferred to a long-term care facility.[10] This devastating result occurred all because a Catholic hospital prioritized religious doctrine over a woman's life.

A patient's right to make her own decisions related to the medical care she receives—individual autonomy—is a tenant of healthcare delivery in the United States, having been reiterated in court opinions for over a century.[11] Autonomy can be defined as "the capacity to live one's own life according" to their own reasons and motives, "not [being] the result of outside manipulating or distorting forces."[12] In the medical context, patient autonomy is furthered by the fiduciary relationship that exists between a patient and her physician; a relationship that begets duties of honesty[13] and loyalty[14] of the physician. These duties, and the concept of autonomy, overlap with the obligation to obtain informed consent before providing certain treatments,[15] requiring physicians to honestly advise patients of risks, alternatives, and potential outcomes before delivering care.[16]

---

10. *Id.*

11. Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2323 (2016) (recognizing that abortion is a choice centered on personal dignity and autonomy, based on prior precedent of the Supreme Court of the United States); Thor v. Superior Court, 855 P.2d 375, 381 (Cal. 1993) (explaining that healthcare decisions "concern one's subjective sense of well-being" and is a "right of personal autonomy . . . ."); McQuitty v. Spangler, 976 A.2d 1020, 1031 (Md. 2009) (explaining that "personal autonomy and personal choice" are recognized as being "the primary foundations of the informed consent doctrine."); Armstrong v. State, 989 P.2d 364, 375 (Mont. 1999) (noting that "the right of each individual to make medical judgements affecting her or his bodily integrity" is a fundamental right encompassed in Montana's state Constitution); Selina Spinos, *Lean on Me: A Physician's Fiduciary Duty to Disclose Emergent Medical Risks to the Patient*, 86 WASH. U. L. REV. 1167, 1185 (2009) (quoting Justice Cardozo's statement in Schloendorff v. Soc'y of New York Hosp., 105 N.E. 92, 93 (N.Y. 1914)) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body.").

12. John Christman, *Autonomy in Moral and Political Philosophy*, *in* THE STANFORD ENCYCLOPEDIA OF PHILOSOPHY (Edward N. Zalta ed., rev. ed. 2018), https://plato.stanford.edu/archives/spr2018/entries/autonomy-moral/.

13. Spinos, *supra* note 11, at 1172–73.

14. *Id.* at 1187–88, 1200, 1203–04.

15. *Id.* at 1205.

16. Jessica De Board, *Informed Consent*, *in* ETHICS IN MEDICINE (2014), https://depts.washington.edu/bioethx/topics/consent.html.

Physicians must further comply with established standards of care in providing treatment to keep patients safe and to avoid malpractice liability.[17]

Medical standards of care have developed over time and guide physicians in providing legitimate treatment options for their patients.[18] These standards commonly evolve from evidence-based research and the study of medical science.[19] Considering the complexities of the human body, medicine is a highly specific field that continues to progress with scientific and technological advances. Physicians are obligated by the aforementioned duties to remain educated and up to date on how to apply these advances to more safely practice within their field.

During litigation, expert witnesses generally establish medical standards of care[20] based on how other physicians would have responded to the situation at hand. However, because there are typically multiple ways to treat a certain diagnosis, there is often room for argument as to what a certain standard of care should be.[21] A poor outcome or an unusual treatment does not automatically result in a breach of the standard of care.[22] The test to determine if a breach occurred generally asks whether the physician used the "level of skill,

---

17. *What is Medical Malpractice?*, AM. BOARD OF PROF. LIABILITY ATT'YS, http://www.abpla.org/what-is-malpractice (last visited May 11, 2018); *see also* Tara Ramanathan, *Law as a Tool to Promote Healthcare Safety*, 19 CLINICAL GOVERNANCE: AN INT'L J. 172, 174–77 (2014).

18. *See* Christina Bielaszka-DuVernay et al., *Health Policy Brief: Improving Quality and Safety*, HEALTH AFF. 2 (Apr. 15, 2011), https://www.healthaffairs.org/do/10.1377/hpb20110415.536210/full/healthpolicybrief_45.pdf (explaining how the National Committee for Quality Assurance, founded in 1990, has set forth standards to improve quality of care that are widely used by health plans); *cf.* Ramanathan, *supra* note 17, at 172–75 (noting how "attention and resources have been devoted to" standards of care surrounding safe injection practices but that unsafe practices continue to arise).

19. *See, e.g.*, *Clinical Guidelines and Recommendations*, AGENCY FOR HEALTHCARE RES. & QUALITY (Nov. 2014), https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/index.html.

20. Charles Markowitz, *Medical Standard of Care Jurisprudence as Evolutionary Process: Implications Under Managed Care*, 2 YALE J. HEALTH POL'Y, L. & ETHICS 59, 66 (2013).

21. Peter Moffett & Gregory Moore, *The Standards of Care: Legal History and Definitions: The Bad and Good News*, 12 W. J. EMERGENCY MED. 109, 111 (2011).

22. *Id.*

knowledge, and care in diagnosis and treatment [of the patient] that other reasonably careful [physicians in that field] would use in the same or similar circumstances."[23] Evaluating the specific circumstances of a situation is key in malpractice litigation. For example, certain medical diagnoses are difficult to detect and it may be unreasonable to expect an accurate and timely diagnosis by a physician before the patient suffers injury.[24] It is important to understand that situations such as this occur, and that our healthcare system cannot fully accommodate all medical diagnoses that exist today. However, this contrasts with a situation where a physician knows or should know of a diagnosis, but simply refuses or neglects to treat the patient. Even worse are situations where physicians deliberately withhold health information from their patients, thereby violating duties of honesty and loyalty. Knowingly ignoring medical concerns or choosing not to address them—especially when established treatment options are available—is clearly unreasonable and falls below the appropriate standard of care. Without a comprehensive understanding of the material facts relevant to their diagnosis, a patient cannot act with autonomy and their consent can hardly be considered informed.

Despite the massive body of law that exists to ensure the safe practice of medicine,[25] physicians working in Catholic hospitals are restricted from offering standard treatment options when faced with certain diagnoses.[26] This comment examines this problem in the context of reproductive-type diagnoses by challenging the means in which Catholic health systems impose religious restrictions on physicians and patients within non-Catholic hospitals. For decades, Catholic-affiliated

---

23. JUDICIAL COUNCIL OF CALIFORNIA CIVIL JURY INSTRUCTIONS, NO. 501 (rev. ed. 2010); *see also* MODEL UTAH JURY INSTRUCTIONS, NO. CV301C (2nd ed. 2014).

24. *Cf.* Moffett & Moore, *supra* note 21, at 111 (explaining that multiple physicians were not liable for failing to diagnose an aortic aneurysm before it resulted in the patient's death).

25. *See generally* MED. BD. OF CAL., GUIDE TO THE LAWS GOVERNING THE PRACTICE OF MEDICINE BY PHYSICIANS AND SURGEONS (7th ed. 2013) (summarizing the many laws set forth for the purpose of ensuring the safe practice of medicine).

26. *Cf.* Elizabeth Sepper, *Zombie Religious Institutions*, 112 NW. U. L. REV. 929, 935 (2018) [hereinafter *Zombie Institutions*] (explaining that "[a]ssisted reproductive technology, abortion, contraception, condoms, sterilization," and additional treatment options are not permitted in Catholic healthcare facilities, and that "patients may only be informed of 'morally legitimate alternatives.'").

hospitals have partnered, merged, and associated with both secular and non-secular organizations.[27] As a result, these institutions have become bound by Catholic ideology limiting their ability to provide proper reproductive care to their patients.[28] The most recent wave of these mergers was with the implementation of the Affordable Care Act, which incentivizes market consolidation.[29]

The problem arises when Catholic health systems enter into contractual merger agreements with non-Catholic healthcare organizations. These contracts contain provisions that force both merging Catholic and non-Catholic hospitals to abide by the Ethical and Religious Directives for Catholic Health Care Services ("*Directives*").[30] Alarmingly, the *Directives* prohibit many scientifically sound procedures that fall within the scope of women's reproductive health.[31] Under the *Directives*, physicians are permitted to advise only "morally legitimate alternatives" to many reproductive-type treatments, thereby preventing or substantially limiting a

27. *See id.* at 937 (discussing how Catholic hospitals began merging with non-Catholic hospitals in the 1990s, and that the Affordable Care Act led to more recent consolidations); Lisa C. Ikemoto, *When a Hospital Becomes Catholic*, 47 MERCER L. REV. 1087, 1087–89 (1996) (discussing the implications of Catholic hospital mergers in 1996).

28. *See generally* CATHOLICS FOR CHOICE, IS YOUR HEALTH CARE COMPROMISED? HOW THE CATHOLIC DIRECTIVES MAKE FOR UNHEALTHY CHOICES (2017) [hereinafter HEALTH CARE COMPROMISED].

29. Christopher Pope, *How the Affordable Care Act Fuels Health Care Market Consolidation*, THE HERITAGE FOUND. (Aug. 1, 2014), http://www.heritage.org/health-care-reform/report/how-the-affordable-care-act-fuels-health-care-market-consolidation#_ftn1 (explaining that new regulations dispose of certain anticompetitive policies, allowing organizations to "dominate local markets.").

30. *See Zombie Institutions*, *supra* note 26, at 935 (explaining that "[w]ithin Catholic healthcare facilities, all providers must comply with religious restrictions on care."); *see generally* HEALTH CARE COMPROMISED, *supra* note 28 at 6 (explaining that the many people who receive care from Catholic and seemingly non-Catholic healthcare systems, "are unaware that these binding, doctrinally based rules exist . . . .");

31. Rebecca Plevin, *Some Catholic Hospitals Limit Treatment for Pregnancy Complications*, 89.3KPCC (Jan. 13, 2016), http://www.scpr.org/blogs/health/2016/01/13/18103/some-catholic-hospitals-limit-treatment-for-pregna/.

physician's ability to safely practice medicine.[32] Patients receiving truncated or abridged information regarding their medical condition are essentially robbed of autonomous choice, leaving the Catholic Church to dictate the scope and direction of their medical treatment.[33]

Many secular hospitals provide reproductive care that the *Directives* restrict.[34] However, once these secular hospitals merge with Catholic institutions, previously provided procedures become barred by the *Directives* and begin to disappear.[35] Not only does this practice disregard the equal treatment of men and women within our healthcare system, but women's safety is compromised during reproductive emergencies.[36]

This comment proposes that the contractual provisions binding secular hospitals to the *Directives* are void for illegality, based on federal legislation that contradicts these agreements and strong public policy concerns that impact society as a whole. Part II provides background information on Catholic-affiliated hospitals, operations under the *Directives*, and the impact the *Directives* have on patient care. Part III describes the implications of these contractual provisions within the healthcare setting, including the disregard for evidence-based standards. Despite the multitude of reasons behind the legislation giving rise to the current standards of care, Catholic hospitals are exempt from these requirements based on religious affiliation. Part IV argues that the doctrine of illegality can serve as a legitimate challenge to these contractual provisions, specifically focusing on contrary legislation and societal interests centered on public policy.

---

32. U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 20 (5th ed. 2009) [hereinafter DIRECTIVES], http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf; *see also* HEALTH CARE COMPROMISED, *supra* note 28, at 5.

33. *Cf.* HEALTH CARE COMPROMISED, *supra* note 28, at 5, 20.

34. *See id.* at 21, 24–25.

35. *Id.*

36. KAYE ET AL., *supra* note 1, at 12.

II. THE CATHOLIC INFLUENCE ON MEDICINE

The *Directives* govern both medical and ethical policies within Catholic hospitals throughout the United States.[37] The current set of *Directives* was issued in 2009 by the United States Conference of Catholic Bishops ("USCCB").[38] In its entirety, the document is forty-three pages long and includes seventy-two directives that dictate medical and ethical issues identified by the USCCB.[39] The *Directives*' origins date back to 1921, when Reverend Michael Burke released a one-page set that many dioceses accepted and hung on operating room walls.[40] However, this original document was more of a list of "do's and don'ts," rather than direct authority, and included prohibitions on sterilization and surgical procedures that terminated fetal life.[41]

With scientific and medical advances, more lengthy versions of the *Directives* were released.[42] During the 1960's, some dioceses interpreted the *Directives* more liberally than others, specifically with regard to women's reproductive care.[43] But during the 1970's, women began gaining more reproductive freedom and the "actual promulgation [of the *Directives*] in each diocese was encouraged" by (what is now) the USCCB.[44] Consistent application of the *Directives* was necessary

---

37. *The ERD's*, CATH. WATCH, catholicwatch.org/policies/ (last visited Aug. 29, 2017) (stating that "Medical and ethical policies in Catholic hospitals and medical systems are governed by the Religious and Ethical Directives for Catholic Health Care . . . ."); *see also* HEALTH CARE COMPROMISED, *supra* note 28, at 20 (explaining that after a secular hospital merged with a Catholic-run healthcare system, the seemingly secular organizations removed tubal ligations from its website as a treatment option).

38. DIRECTIVES, *supra* note 32, at 1, 43. The USCCB is a Washington D.C. corporation made up of bishops, priests, deacons, and lay people for the purpose of promoting Catholic ideology within the United States. *About USCCB*, U.S. CONF. OF CATH. BISHOPS, www.usccb.org/about/ (last visited May 11, 2018) [hereinafter *About USCCB*].

39. *See* DIRECTIVES, *supra* note 32.

40. Kevin D. O'Rourke et al., *A Brief History: A Summary of the Development of the Ethical and Religious Directives for Catholic Health Care Services*, 82 HEALTH PROGRESS 18, 18 (2001)

41. *Id.*

42. *See id.*

43. *Id.* at 19.

44. *Id.*

for Catholic institutions to exercise federal conscience clause rights,[45] which exempt religious facilities from providing morally controversial care. Different versions and supplements of the *Directives* were released over time, including the 1994 version, which addressed growing healthcare partnerships and the concept of material cooperation.[46]

The crux of the *Directives* is the idea that Catholic hospitals cannot engage in or cooperate with "intrinsically evil" acts.[47] Among others, the *Directives* lists abortion, sterilization, and assisted suicide as "intrinsically evil."[48] There are different levels of material cooperation, and certain forms may be acceptable for "proportionate reasons."[49] For example, voting for a pro-life political candidate would constitute "remote material cooperation" and could potentially be justified given the circumstances.[50] Material cooperation could be something as simple as an employee sweeping the floor of an abortion clinic,[51] even if the employee does not believe in the procedure and simply needs the job to support their family.[52] However, no matter how tangential the connection is to the "intrinsically evil" act itself, some will argue that "nothing is proportionate to the great evil of abortion."[53]

The most current *Directives*, authored by the USCCB in 2009, carry on the prohibition against material cooperation with regard to abortion services.[54] The effects are manifested when a secular hospital partners, affiliates, or merges with a Catholic hospital.[55] Because Catholic

45. *Id.*

46. *Id.* at 20.

47. DIRECTIVES, *supra* note 32, at 42.

48. *Id.*; O'Rourke et al., *supra* note 40, at 21.

49. M. Cathleen Kaveny, *Catholics as Citizens: Today's Ethical Challenges Call for New Moral Thinking*, AM.: THE JESUIT REV. (Nov. 1, 2010), https://www.americamagazine.org/issue/753/article/catholics-citizens.

50. *Id.*

51. Brian Thomas Becket Mullady, *Formal and Material Cooperation*, HUM. LIFE INT'L: TRUTH AND CHARITY F. (Oct. 4, 2012), http://truthandcharity forum.org/formal-and-material-cooperation/.

52. Randall Smith, *No Cooperation with Evil*, THE CATH. THING (Mar. 4, 2012), https://www.thecatholicthing.org/2012/03/04/no-cooperation-with-evil/.

53. Kaveny, *supra* note 49.

54. DIRECTIVES, *supra* note 32, at 26, 37, 42.

55. *See id.*

hospitals cannot take part in the material cooperation of intrinsically evil procedures, contractual agreements are formed that bind secular hospitals to this religious doctrine.[56] The implications of a binding agreement predicated on a continuously evolving doctrine is a serious concern, especially when the effects fall on vulnerable healthcare consumers who never took part in the bargaining process.

A. Catholic Medicine

Although this comment emphasizes the ways in which the Catholic Church has negatively impacted healthcare, this was not always the case. Historically, these institutions were created and run by sisters of the Church, focused on serving the indigent population through charitable care.[57] Catholic hospitals were dedicated to following the mission of Christ to serve others by caring for vulnerable members of the population who lacked the means to care for themselves.[58] Even today, the *Directives* provide that Catholic-affiliated institutions must stand apart by serving "those in need," specifying persons who are "particularly vulnerable to discrimination."[59] Among others, the *Directives*' list of those in need includes the poor, uninsured, elderly, single parents, racial minorities, and those with incurable diseases.[60]

Unfortunately, many of these populations are now discriminated against by Catholic organizations,[61] and charitable care (dependent on donations) is no longer the hallmark of these institutions.[62] Private insurers and the federal government—through Medicare and Medicaid

---

56. *See generally id.*

57. Michael Greenstein, *The Evolution of the U.S. Catholic Hospital: From Sisters in Habits to Men in Suits* 7–8 (Celebrating Scholarship & Creativity Day, Paper No. 88, 2016), http://digitalcommons.csbsju.edu/cgi/viewcontent.cgi?article=1087&context=elce_cscday.

58. *Id.* at 6.

59. *See generally* DIRECTIVES, *supra* note 32.

60. *Id.* at 11–12.

61. *See* Memorandum from the Catholics for Choice on The Ethical and Religious Directives for Catholic Healthcare Services 6–7 (Apr. 2011), http://www.catholicsforchoice.org/wp-content/uploads/2014/01/CFC Memoonthe Directivesweb.pdf (noting how populations such as pregnant women, the poor, and sexual assault victims are adversely impacted by the directives).

62. *Zombie Institutions*, *supra* note 26, at 9.

programs—now provide funding.[63] Catholic organizations often appear indistinguishable from their secular counterparts, but are allotted religious exemptions in terms of the care provided.[64] Today, on average, Catholic hospitals actually provide less charitable care than secular hospitals.[65]

While lacking in charitable care—the area meant to set these organizations apart—Catholic hospitals are currently capable of, and likely do provide more than adequate treatment to certain members of the indigent population. However, not all patients are treated equally. Catholic affiliated institutions bound by the *Directives*, restrict physicians in their ability to offer reproductive healthcare.[66] Thus, when patient care collides with the *Directives*, the patients suffer. Women are turned away when seeking an abortion, even if the necessity arises from a spontaneous miscarriage.[67] Same-sex couples cannot seek fertility treatment for themselves or potential surrogates because, according to the Church, that does not respect the sanctity of marriage.[68] Catholic hospitals may also refuse to counsel sexually active patients on the use of condoms to prevent the risk of transmitting HIV or other STDs based on an opposition to birth control.[69]

It is not just that Catholic health systems can refuse to provide services such as medically necessary abortions, tubal ligations, or fertility treatments, though this is a major issue in itself. Providers are prevented from even counseling patients on these services as viable treatment options.[70] Providers are barred from fully informing their

63. *Id.*

64. *Id.* at 22–23.

65. HEALTH CARE COMPROMISED, *supra* note 28, at 7 (explaining that the average charity care provided by Catholic hospitals is less than that provided by public hospitals, at 2.8 percent compared to 5.6 percent).

66. DIRECTIVES, *supra* note 32, at 25–28.

67. *Id.* at 26; *see also Fact Sheet: Health Care Refusals Harm Patients: The Threat to Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (May 2014) [hereinafter NAT'L WOMEN'S L. CTR.], https://nwlc.org/wp-content/uploads/2015/08/refusals_harm_patients_repro_factsheet_5-30-14.pdf.

68. DIRECTIVES, *supra* note 32, at 25.

69. NAT'L WOMEN'S L. CTR., *supra* note 67.

70. Priyanka Ray, *The Ethics of Catholic Hospitals Refusing Treatment Information to Patients*, THE BIOETHICS PROJECT, http://blogs.kentplace.org/bioethicsproject/2016/02/08/the-ethics-of-catholic-hospitals-refusing-treatmentinformation-to-patients/ (last visited May 11, 2018).

patients on certain diagnoses to avoid having to provide treatment that conflicts with the *Directives*,[71] as this constitutes material cooperation. But withholding information strips patients of the ability to make an informed choice and puts them in a dangerous position. This was precisely the case for Mindy Swank, who was twenty-weeks pregnant when a spontaneous miscarriage caused her water to break.[72]

Mindy went to a Catholic hospital where she had previously been treated, and faced risks of infection and hemorrhage when the hospital refused to perform an abortion.[73] She was sent home and forced to continue a pregnancy that could not be brought to term.[74] Over the next seven weeks, Mindy and her husband went back and forth from home to hospital requesting the staff to complete her miscarriage and end her emotional suffering.[75] Abiding by the *Directives*, the hospital continued to refuse the procedure until Mindy experienced severe hemorrhaging at twenty-seven weeks.[76] Labor was finally induced and as known all along, the fetus did not survive.[77]

During this ordeal, Mindy was never advised that she could have an abortion at a separate facility.[78] Based on testing, hospital staff knew the fetus would not survive, but continued to delay due-care.[79] Mindy could have undergone a less traumatic surgical procedure under anesthesia when this was discovered at twenty-weeks.[80] However, once pregnancies reach twenty-four weeks, inducing labor is generally the only option.[81] Mindy was forced to deliver a child that she knew would not survive,[82] exacerbating her emotional pain that could have been mitigated seven weeks prior.

---

71. *Id.*
72. KAYE ET AL., *supra* note 1, at 8.
73. *Id.*
74. *See id.*
75. *Id.* at 8–9.
76. *Id.* at 9.
77. *Id.*
78. *Id.*
79. *Id.*
80. Dep't of Obstetrics & Gynecology, *Understanding Second Trimester Loss*, UC DAVIS HEALTH, https://www.ucdmc.ucdavis.edu/obgyn/services/FP/trimester_loss.html (last visited May 11, 2018).
81. *Id.*
82. KAYE ET AL., *supra* note 1, at 9.

A similar story comes from a patient of Dr. Rebecca Cohen, who experienced an unplanned pregnancy after believing a tubal ligation had been performed following a past pregnancy.[83] At a secular hospital, the patient consented to the tubal ligation while receiving her prenatal care.[84] However, after going into labor, she was taken to the nearest medical facility due to complications in the fetal position.[85] Upon arrival, the patient provided hospital staff with consent for both the tubal ligation and the cesarean section.[86] Unfortunately, the hospital was bound to the *Directives* and, unbeknownst to the patient, the tubal ligation was never performed.[87] Upon discovering her subsequent unplanned pregnancy, the patient was devastated and while sobbing asked her physician, "I'm not even Catholic—where are my rights?"[88] These disheartening anecdotes distill a truth: patient rights in Catholic hospitals are ultimately controlled by local Catholic Bishops.[89]

B. The Power of Catholic Bishops

The *Directives* command that Catholic hospitals protect the life of the unborn;[90] yet the woman's life seems to be forgotten. The pro-life theory exposes hypocrisy when Catholic doctrine place women's lives in danger by forcing hospitals to refuse to terminate pregnancies that carry no chance of fetal survival.[91]

This is concerning because the USCCB strictly enforces the use of the *Directives* in Catholic hospitals.[92] In fact, Catholic sisters have been

---

83. *Id.* at 21.
84. *Id.*
85. *Id.*
86. *Id.*
87. *Id.*
88. *Id.*
89. *See* Erica Hellerstein & Josh Israel, *A Bishop In The Exam Room: When Faith Dictates Health Care Instead Of Science*, THINK PROGRESS (June 22, 2016, 1:48 PM), https://thinkprogress.org/a-bishop-in-the-exam-room-when-faith-dictates-health-care-instead-of-science-69cb73f4ab80; *see also* HEALTH CARE COMPROMISED, *supra* note 28, at 21.
90. DIRECTIVES, *supra* note 32, at 11, 23, 26, and 27.
91. KAYE ET AL., *supra* note 1, at 8.
92. *See* HEALTH CARE COMPROMISED, *supra* note 28, at 21, 24–25.

reprimanded for promoting beliefs contradictory to the *Directives*,[93] and more specifically, for allowing physicians to remove an unborn fetus.[94] Sister Margaret McBride was one such sister, who was excommunicated after approving a medically necessary abortion when failing to do so would have resulted in a woman's death.[95] McBride thought her actions were permissible based on *Directive* number 47, which affords an exception to the abortion ban when a mother's condition is serious enough and the procedure cannot be safely postponed.[96] However, the threat of death was not serious enough for Bishop Thomas J. Olmsted who declared McBride excommunicated for allowing the procedure to take place.[97]

Local Bishops hold the decision-making power when it comes to patient care and hospital mergers.[98] The *Directives* provide that joint venture agreements be overseen by Bishops, who have the authority to halt these agreements and change the terms as time goes on.[99] In many cases, Bishops later barred certain procedures that were allowed under the original terms.[100] Considering that local Bishops change with time, interpretations of what is consistent with the *Directives* may change as well and these merger agreements allow for this.[101] Inconsistent interpretations of the *Directives* weakens the claim that certain

93. *U.S. Nuns Face Vatican Rebuke for "Radical Feminism" in Stances on Church Teachings, Social Justice*, DEMOCRACY NOW! (Apr. 27, 2012), https://www.democracynow.org/2012/4/27/us_nuns_face_vatican_crackdown_for.

94. Barbara Bradley Hagerty, *Nun Excommunicated for Allowing Abortion*, NAT'L PUB. RADIO (May 19, 2010, 3:00 PM), http://www.npr.org/templates/story/story.php?storyId=126985072; *see also* HEALTH CARE COMPROMISED, *supra* note 28, at 4.

95. Hagerty, *supra* note 94.

96. *Id.*; DIRECTIVES, *supra* note 32, at 26.

97. *See* Hagerty, *supra* note 94.

98. HEALTH CARE COMPROMISED, *supra* note 28, at 21.

99. *Id.*

100. *Id.*; *see also* Monica Sloboda, *The High Cost of Merging with a Religiously-Controlled Hospital*, 16 BERKELEY WOMEN'S L.J. 140, 145 (2013) (describing how a Texas hospital was permitted to perform sterilizations until a local archbishop altered hospital policies to conform with the Vatican); HEALTH CARE COMPROMISED, *supra* note 28, at 21.

101. HEALTH CARE COMPROMISED, *supra* note 28, at 21–22 (explaining how "[t]he new agreement provided that the University Hospital must 'respect' Catholic policies.").

procedures are against the morals of the Catholic Church, as these moral determinations appear to depend on who is in charge on a given day.

Although Catholic hospitals used to be run by sisters of the Church, the role of these women in Catholic institutions has been declining for decades.[102] The number of sisters within the Catholic Church as a whole declined by 72 percent between 1965 and 2014.[103] Their declining role also holds true in the context of Catholic hospitals, where fewer sisters serve as chief executives for these organizations.[104] The result is the quieting of the female voice from both a patient and administrative perspective.[105]

C. Financial Advantages

During joint-ventures, it is likely the financial advantages that motivate secular and non-Catholic[106] organizations to agree to abide by the *Directives*.[107] To hospital administrators, these incentives may outweigh the loss of certain services in the short-run. For example, being part of a larger health system results in a bigger cut of the market share.[108] Thus, individual secular organizations may merge with a larger Catholic systems to gain more bargaining power when it comes to negotiating rates with insurance providers.[109] Larger systems can

---

102. *Id.* at 5.

103. *Id.*

104. *Id.*

105. When there are fewer women present to advocate for necessary reproductive rights, female patients are impacted when those rights are diminished.

106. Some hospitals are not Catholic, but associate with different religious views. HEALTH CARE COMPROMISED, *supra* note 28, at 22 (discussing a merger between a Catholic health system and a Jewish hospital that affected the services provided by the Jewish hospital).

107. *See generally* MONICA NOETHER & SEAN MAY, HOSPITAL MERGER BENEFITS: VIEWS FROM HOSPITAL LEADERS AND ECONOMETRIC ANALYSIS 4–5 (2017).

108. Gregory Curfman, *Everywhere, Hospitals are Merging—But Why Should You Care?*, HARV. HEALTH PUB. (Apr. 1, 2015, 5:00 PM), www.health.harvard.edu/blog/everywhere-hospitals-are-merging-but-why-should-you-care-201504017844.

109. *Id.*; *see also* Julie Appleby, *As They Consolidate, Hospitals Get Pricier*, KAISER HEALTH NEWS (Sept. 26, 2010) (describing how increased bargaining power can allow hospitals to drive up costs, causing tension between hospitals and insurers).

also save on supplies and equipment through discounted large volume purchases, as well as Information Technology costs associated with electronic health records ("EHR").[110] Epic, for example, is an EHR program that allows for the seamless flow of healthcare data[111] and has been shown to improve patient safety.[112] Merging with a Catholic organization that uses Epic may seem worth the loss of certain services if it will improve safety in other areas of the hospital. Some additional benefits of mergers include: standardized patient care; the ability to engage in high-risk, high-reward arrangements; and more hiring power to attract top talent for management positions.[113]

Another financial component to joint-ventures relates to who has the upper hand during negotiations.[114] Catholic hospitals' bargaining power is increased because of its tax-exempt status.[115] Catholic hospitals are not subject to the same tax requirements as for-profit organizations, which often puts Catholic institutions in a better financial position.[116] Catholic hospitals operate under religious affiliation, which qualifies these institutions for non-profit 501(c)(3) tax-exempt status.[117] Benefits of 501(c)(3) status can include exemption from federal income tax on net income, increased borrowing eligibility through tax-exempt bonds, more appealing donors (based on charitable deduction qualifications), and exemptions from property and sales taxes in certain states.[118]

---

110. NOETHER & MAY, *supra* note 107, at 4–5.

111. Yale Ctr. for Clinical Investigation, *Epic: Changing the Way Medicine is Practiced*, YALE SCH. OF MED. (2014), http://ycci.yale.edu/news/newsletter/winter2014newsletter/epic.aspx.

112. *Improving Patient Safety*, NORTH SHORE U. HEALTH SYS., https://www.northshore.org/about-us/quality-patient-safety/patient-safety/improving-patient-safety/ (last visited May 11, 2018).

113. NOETHER & MAY, *supra* note 107, at 4–5.

114. *See* HEALTH CARE COMPROMISED, *supra* note 28, at 20.

115. *See id.*

116. *Id.*; Sabrina Dunlap, *When Views Collide: How Hospital Mergers Restrict Access to Reproductive Health Care*, 2 HEALTH L. & POL'Y BRIEF 30, 31 (2013) (noting how Catholic hospitals benefit from tax-exemptions given that these institutions having "tremendous clout in the industry.").

117. I.R.C. § 501(c)(3) (2012).

118. Bernadette M. Broccolo, *Tax-Exempt Issues*, *in* FUNDAMENTALS OF HEALTH LAW 217, 218 (6th ed. 2014).

Accordingly, holding 501(c)(3) status ultimately translates into increased bargaining power during the merger negotiation process.[119] To illustrate, during the summer of 2015, Crittenton Hospital Medical Center merged into the Catholic network of Ascension Health Michigan.[120] Crittenton suffered a $22.2 million loss in operations during 2013 while Ascension profited from investments not subject to taxes.[121] Ascension's net income from its investments was $1.2 billion in 2007.[122] When Crittenton merged into Ascension's network, its CEO claimed the impact on hospital services would be limited.[123] However, tubal ligations were removed from Crittenton's website as an offered service in 2016.[124] Tax benefits exist on a local level as well. For example, county property taxes in the state of Washington—totaling a $1.5 million subsidy—were contractually shifted to fund a Catholic healthcare organization, creating a monopoly in a rural area of the state.[125]

The Catholic Church's financial advantages have helped it gain control of a large segment of the healthcare field. In rural areas especially, this deprives individuals of non-religious alternatives for healthcare. Religious freedom is fundamental to society, and individuals should have the right to choose what they believe. The guarantee of religious freedom, encapsulated in the First Amendment and forged in the foundation of the United States,[126] must be voluntary in order for it to function properly. That religious adherence is put into contractual terms implies coercion versus a voluntary affiliation with religious beliefs.[127]

---

119. *See* HEALTH CARE COMPROMISED, *supra* note 28, at 20.

120. *Id.*

121. *Id.*

122. *Id.*

123. *Id.*

124. *Id.*

125. *Id.* (describing how County Public Hospital District No. 1 contracted with San Juan, Washington to "collect property taxes to fund PeaceHealth" and included provisions barring the District from competition).

126. U.S. CONST. amend. I.

127. Elizabeth Sepper, *Contracting Religion*, *in* LAW, RELIGION, AND HEALTH IN THE UNITED STATES (Holly Fernandez Lynch, I. Glenn Cohen & Elizabeth Sepper eds., forthcoming 2017), https://papers.ssrn.com/sol3/papers.cfm?abstract_id =2783518.

D. The Catholic Hospital Take Over

Mergers, partnerships, and associations have led to a rise in Catholic owned and affiliated institutions, which now make up greater than 14 percent of hospitals throughout the United States.[128] Catholic hospitals increased by 22 percent from 2001 to 2016, while there was a 6 percent decline in the number of acute care hospitals as a whole.[129] Currently, the largest Catholic health system in the nation controls 384 hospitals, compared to 330 in 2011.[130] These consolidations leave rural areas with fewer options for healthcare treatment.[131] In fact, there are forty-six Catholic hospitals restricted by the *Directives* serving as sole community providers in rural areas.[132] Catholic hospitals are the only choice for individuals in these communities,[133] especially during medical emergencies. However, this issue is not limited to rural areas; even in Manchester, the largest city in New Hampshire, a hospital refused to provide an abortion because of the *Directives* when Kathleen Prieskorn suffered a tear in her amniotic sac.[134] Kathleen had no health insurance, no car, and the nearest hospital willing to perform the necessary procedure was eighty miles away.[135] After being refused, Kathleen's physician gave her $400 and she traveled the eighty miles in a cab, knowing that if any complications occurred she may not only lose her uterus, but her life.[136] Kathleen's story makes sense, bearing in mind that one in every six hospital beds in the United States is tied to Catholic ownership or affiliation.[137] Thus, millions of people—both

---

128. LOIS UTTLEY & CHRISTINE KHAIKIN, GROWTH OF CATHOLIC HOSPITALS AND HEALTH SYSTEMS: 2016 UPDATE OF THE MISCARRIAGE OF MEDICINE REPORT 1 (2016).

129. *Id.*

130. *Id.*

131. *Id.*; *see also* Molly M. Ginty, *Treatment Denied*, MS. MAG. (Spring 2011), http://www.msmagazine.com/spring2011/treatmentdenied.asp.

132. UTTLEY & KHAIKIN, *supra* note 128, at 1.

133. *See generally* Ginty, *supra* note 131.

134. *See id.*

135. *Id.*

136. *Id.*

137. *See* UTTLEY & KHAIKIN, *supra* note 128, at 1. Considering the large number of Catholic hospital beds in the United States, stories like this must be

Catholic and non-Catholic—are treated within these Catholic institutions[138] and subject to a different standard of care regardless of their own beliefs.

Local Bishops have the power to oversee joint-venture contracts, which allows them to make important healthcare decisions on behalf of women across the United States.[139] Allowing someone with no medical training to make decisions that lack scientific support would seem outrageous to most. Picture a young man walking into an emergency room with abdominal pain. Upon further assessment, a physician discovers the man has appendicitis but chooses not to tell the man because the hospital associates with a religion that does not allow for the removal of a "living organ." The physician sends the patient home with Tylenol and no notice that his condition could result in sepsis or even death. The young man depended on the medical advice he received and his life was risked by a third-party's religious beliefs while his own beliefs were cast aside. Although this scenario seems absurd, as discussed below, this situation is hauntingly similar to what women across the United States may experience upon entering Catholic hospitals. And keeping patients in the dark as to what is going on with their bodies can result in death.[140]

III. REPRODUCTIVE STANDARDS OF CARE AND PHYSICIAN OBLIGATIONS

Patients depend on physicians to free them of mistaken beliefs regarding medical conditions.[141] When a physician intentionally fails to disclose an emergent medical risk, he or she violates the fiduciary duty owed to the patient.[142] The serious harms that may result from non-

---

somewhat common for women of reproductive age who only have access to Catholic health services.

138. HEALTH CARE COMPROMISED, *supra* note 28, at 26.

139. *See generally* Hellerstein & Israel, *supra* note 89.

140. *See Woman Dies After Abortion Request 'Refused' at Galway Hospital*, BBC NEWS (Nov. 14, 2012), http://www.bbc.com/news/uk-northern-ireland-20321741 (a woman died of sepsis after a Catholic facility, in Ireland, refused to perform a necessary abortion).

141. Albert W. Wu et al., *To Tell the Truth: Ethical and Practical Issues in Disclosing Medical Mistakes to Patients*, 12 J. OF GEN. INTERNAL MED. 770, 772 (1997).

142. Spinos, *supra* note 11, at 1169.

disclosure can be avoided by simply voicing the risks to the patient.[143] Both state and federal law provide incentives for disclosing medical information, largely in the context of adverse events (i.e. medical errors).[144] Although the context is different in cases where information is deliberately withheld following a physician error, the underlying principle is the same: people have the right "to be free of mistaken beliefs of their past, present, or future medical condition."[145]

The American Medical Association's Principles of Medical Ethics sets forth that physicians "must recognize responsibility to the patient first and foremost . . . ."[146] Honesty and "respect for human dignity and rights" is also listed within the Principles.[147] Part of being honest and putting the patient first is disclosing emergent medical risks so that patients can effectively monitor their given condition and be on guard for certain complications.[148] Turning to the famous notion, to "do no harm," health-care providers should adhere to established standards of care to best protect their patients from adverse outcomes.[149]

A. Preterm Premature Rupture of Membrane

Standards of care are used as evidence in medical malpractice cases to prove whether or not a physician negligently treated a patient.[150] Procedures such as abortion have medical standards attached to

143. *Id.*

144. *See generally* Heather Morton, *Medical Professional Apologies Statutes*, NAT'L CONF. OF ST. LEGISLATURES (Jan. 21, 2014), http://www.ncsl.org/research/financial-services-and-commerce/medical-professional-apologies-statutes.aspx.

145. Wu et al., *supra* note 141, at 772.

146. AM. MED. ASS'N, AMA PRINCIPLES OF MEDICAL ETHICS (rev. 2001), https://www.ama-assn.org/sites/default/files/media-browser/principles-of-medical-ethics.pdf.

147. *Id.*

148. *Id.*

149. *See* Diana J. Mason, *Transforming Health Care for Patient Safety: Nurses' Moral Imperative To Lead*, *in* PATIENT SAFETY AND QUALITY: AN EVIDENCE-BASED HANDBOOK FOR NURSES 4 (Ronda G. Hughes ed., 2008).

150. *See* Davis v. Virginian Ry. Co., 361 U.S. 354, 357 (1960); Walski v. Tiesenga, 381 N.E.2d 279, 282 (Ill. 1978); Condra v. Atlanta Orthopaedic Grp., P.C., 681 S.E.2d 152, 154 (Ga. 2009).

them.[151] Caring for a patient with certain pregnancy complications also calls for standard treatment options that should be discussed with and selected by the patient.[152] Preterm premature rupture of membrane ("preterm PROM") is a serious pregnancy complication that holds a high risk for both maternal and neonatal morbidity.[153] The earlier the rupture occurs during a pregnancy, the less likely it is that a fetus will survive.[154] If preterm PROM occurs before fetal viability, the woman should be realistically advised on the likelihood of fetal survival and offered immediate delivery as a treatment option.[155]

Eighteen weeks into her pregnancy, Tamesha Means came to Mercy Health Partners ("Mercy Health") and was diagnosed with preterm PROM.[156] Nobody at the hospital informed Tamesha that her diagnosis put her at risk for complications such as amnionitis, placental abruption, infertility, sepsis, and death.[157] Nor was she informed that at just eighteen weeks, the fetus held virtually no chance of survival.[158] At this point, terminating the pregnancy would have been a standard treatment option for Tamesha to consider, but she was never given the chance.[159]

Given her situation, Tamesha should have been admitted to the hospital.[160] Instead, she was offered pain medication and discharged

---

151. *See generally* WORLD HEALTH ORG., CLINICAL PRACTICE HANDBOOK FOR SAFE ABORTION (2014).

152. Caughey et al., *supra* note 5, at 16; *see also* Waters & Mercer, *supra* note 5, at 237.

153. Caughey et al., *supra* note 5, at 13; *see also* Waters & Mercer, *supra* note 5, at 237.

154. *See* Brief for Obstetrician-Gynocologists as Amici Curiae Supporting Appellant at 7–8, Means v. United States Conference of Catholic Bishops, 836 F.3d 643 (6th Cir. 2016) (No. 15–1779), 2016 WL 211756 [hereinafter Brief of Amici Curiae].

155. *Practice Bulletin No. 172*, *supra* note 5, at 171e.

156. Means v. United States Conference of Catholic Bishops, 836 F.3d 643, 646 (6th Cir. 2016).

157. *Id.* at 646–47; Waters & Mercer, *supra* note 5, at 233.

158. Brief of Amici Curiae, *supra* note 154, at 7–8; *see also Means*, 836 F.3d at 647.

159. Brief of Amici Curiae, *supra* note 154, at 7–8.

160. Caughey et al., *supra* note 5, at 17 (explaining that only select circumstances—requiring immense patient education—allow for a discharge home on bedrest in cases of preterm PROM); *see also Practice Bulletin No. 172*, *supra* note 5,

home.[161] The following day, Tamesha returned to Mercy Health with a fever, while experiencing painful contractions and bleeding.[162] The treating physician suspected Tamesha had acquired chorioamnionitis,[163] a serious infection that puts women at risk for infertility and death.[164] A placental pathology report later confirmed this diagnosis, along with the presence of another bacterial infection.[165] Under these circumstances, Tamesha should have been offered an immediate delivery,[166] but Mercy Health sent her home again; no options were discussed and she was left in the dark as to the seriousness of her diagnosis.[167] As her condition worsened, Tamesha returned that night in excruciating pain and experiencing regular contractions.[168] As Mercy Health was about to discharge her home yet again, Tamesha began to deliver.[169] Within the few short hours following Tamesha's "extremely painful, feet-first breech delivery," the fetus died.[170] This unnecessary sequence of events was a result of Mercy Health's Catholic affiliation and its observance of the *Directives*.[171] Due to a fetal heartbeat that held no chance of survival, Mercy Health prioritized religious doctrine over a woman's life.[172]

Tamesha brought suit against three chair members of the Catholic Health Ministries ("CHM") (sponsors of the system that operates

---

at 171e (explaining that a woman must be advised on monitoring her physical symptoms in the instance she develops an infection, goes into labor, or experiences abruptio placentae).

161. *Means*, 836 F.3d at 646–47.

162. *Id.* at 647; *see also* HEALTH CARE COMPROMISED, *supra* note 28, at 9.

163. *Means*, 836 F.3d at 647.

164. *Id.*; *see also* Brief of Amici Curiae, *supra* note 154, at 6.

165. Brief of Amici Curiae, *supra* note 154, at 8.

166. *Id.* (citing *Practice Bulletin No. 172*, *supra* note 5, at e165).

167. *Id.*; *Means*, 836 F.3d at 647.

168. *Means*, 836 F.3d at 647.

169. Brief of Amici Curiae, *supra* note 154, at 7.

170. *Id.*

171. *Id.*; *see also* Molly Redden, *Abortion Ban Linked to Dangerous Miscarriages at Catholic Hospital, Report Claims*, THE GUARDIAN (Feb. 18, 2016, 10:19 EST), https://www.theguardian.com/us-news/2016/feb/18/michigan-catholic-hospital-women-miscarriage-abortion-mercy-health-partners.

172. *See generally* Brief of Amici Curiae, *supra* note 154.

Mercy Health) and the USCCB.[173] Ordinary negligence was alleged, and the claim against USCCB was dismissed for a lack of personal jurisdiction.[174] Upon review, the appellate court claimed that USCCB did not purposefully avail itself by writing the *Directives* because they did not "impose the Directives on Mercy Health."[175] Instead, USCCB "simply set forth" ethical standards for Catholic healthcare institutions.[176] However, USCCB releases the *Directives* to all Catholic Hospitals throughout the United States.[177] The *Directives* specifically demand that "Catholic health care services must adopt [the] Directives as policy [and] require adherence to them within the institution . . . ."[178]

The *Directives* further instruct a purpose of authoritative guidance for Catholic healthcare services,[179] "address[ing] sponsors, trustees, administrators, chaplains, physicians, health care personnel, and patients or residents" of Catholic institutions.[180] The reach of personal jurisdiction seems broad considering there are Catholic healthcare facilities in all 50 states,[181] but personal jurisdiction should be broad considering that the *Directives* hold the potential to injure women throughout the nation. The *Directives* are intended to guide Catholic healthcare institutions,[182] and that is precisely what they did in the case of Tamesha Means.

The court went on to analyze the claim against the members of CHM, finding facts insufficient to support a claim of negligence.[183] In discussing proximate cause, the court explained that although *Directive* 45 prohibited abortion, *Directive* 47 provided an exception to save a

---

173. *Means*, 836 F.3d at 647.

174. *Id.* at 649.

175. *Id.* at 650.

176. *Id.*

177. *See* DIRECTIVES, *supra* note 32, at 12.

178. *Id.*

179. *Id.* at 4.

180. *Id.*

181. *Facts - Statistics Catholic Healthcare in the United States*, CATH. HEALTH ASS'N OF THE U.S., https://www.chausa.org/about/about/facts-statistics (last updated Jan. 2017).

182. *See* DIRECTIVES, *supra* note 32, at 4.

183. Means v. United States Conference of Catholic Bishops, 836 F.3d 643, 654 (6th Cir. 2016).

woman's life.[184] To the court, it was not clear that the *Directives* caused Mercy Health to treat Tamesha in the way it did because the *Directives* are subject to interpretation.[185] However, there is precedent to support the interpretation that the *Directives* did cause Mercy Health to treat Tamesha inadequately.[186] For instance, as previously mentioned, Bishop Olmstad excommunicated Sister McBride when she allowed an abortion to save a woman's life.[187] While Sister McBride argued her actions were justified because of *Directive* 47's exception, Bishop Olmstad disagreed.[188]

While the arguments against the court's decision in this case continue, Part III seeks to outline a new idea that could have a broader reach in reducing the use of the *Directives* in the healthcare context. The Catholic Church should be held accountable for cases like Tamesha's. Mercy Health deviated from the medical standard of care for preterm PROM,[189] and this was not the first time.[190] County health official, Faith Groesbeck, discovered that Tamesha was one of five women who suffered inadequate medical care at Mercy Health, based on adherence to the *Directives*, in a period of only seventeen months.[191]

Groesbeck released a report detailing the story of one of these women who came to Mercy Health "after seeing a fetal limb in her toilet."[192] Mercy Health staff began dilation, causing the amniotic sac of fluid to bulge outside the woman's cervix.[193] The fetus was not going to survive, and the woman asked the staff to break her water so that she could begin delivery and the process of miscarrying the fetus.[194] Instead, Mercy Health made her wait "over eighteen hours . . . to complete the miscarriage naturally . . . ."[195] This resulted in a retained

184. *Id.* at 653.
185. *Id.*
186. *See generally* Hagerty, *supra* note 94.
187. *See id.*
188. *Id.*
189. *See generally* Caughey et al., *supra* note 5; Waters & Mercer, *supra* note 5.
190. *See generally* Redden, *supra* note 171.
191. *See id.*
192. *Id.*
193. *Id.*
194. *Id.*
195. *Id.*

placenta, which is strongly associated with maternal hemorrhage and death.[196] The placenta tested positive for infection and had to be surgically removed.[197] Mercy Health's deviation from the standard of care placed the woman's life at risk and forced her into surgery.[198] Unfortunately, Groesbeck's position as county health official was eliminated before the investigation was complete,[199] leaving even more potential violations and victims undiscovered.

B. Tubal Ligations

Jennafer Norris fell victim to the *Directives* at a separate facility where she was denied her freedom of choice, while receiving inadequate patient care.[200] At eight weeks pregnant, Jennafer realized her birth control had failed when she started exhibiting symptoms of preeclampsia—a serious pregnancy complication that causes high blood pressure, along with potential organ damage and death if left untreated.[201] The pregnancy was difficult and forced Jennafer to stop working and spend weeks at home on bed rest.[202] At thirty weeks, Jennafer began experiencing blurred vision, excruciating headaches, and increases in blood pressure.[203] Her health was at risk and her family was scared.[204]

Jennafer planned a cesarean delivery and asked the hospital to perform a tubal ligation[205] immediately after delivery to prevent future

196. J. Belachew et al., *Risk of Retained Placenta in Women Previously Delivered by Caesarean Section: A Population-Based Cohort Study*, BJOG: AN INT'L J. OBSTETRICS & GYNECOLOGY 224, 224–25 (2013).

197. Redden, *supra* note 171.

198. *Id.*

199. *Id.* (explaining that Groesbeck quit after she was re-assigned to a substance abuse prevention program that she had not trained for).

200. KAYE ET AL., *supra* note 1, at 19–20.

201. *Preeclampsia: Overview*, MAYO CLINIC, http://www.mayoclinic.org/diseases-conditions/preeclampsia/basics/definition/con-20031644 (last visited May 11, 2018).

202. KAYE ET AL., *supra* note 1, at 19.

203. *Id.* at 20.

204. *Id.* at 19–20.

205. A tubal ligation is a procedure that blocks or cuts the fallopian tubes for the purpose of preventing future pregnancies. *Tubal Ligation: Definition*, MAYO

pregnancies.[206] A sympathetic physician informed Jennafer that the procedure could not be performed due to the *Directives*.[207] Jennafer's only option was to find a different hospital, but staff explained to her that she would be risking having "a stroke or a seizure at any moment."[208] Traveling thirty minutes to a different facility posed too great of a risk.[209] Jennafer was forced to not only accept that she could not have the procedure she desired, but that Catholic doctrine was the governing force behind that decision.[210]

The tubal ligation Jennafer requested is a common procedure.[211] Approximately 10 percent of all births are followed by this operation,[212] 25 percent of American women using birth control rely on this option,[213] and there is little risk added when the procedure is done in concurrence with a cesarean delivery.[214] In fact, the American College of Obstetricians and Gynecologists provides that the period immediately following a cesarean delivery is an ideal time for the procedure.[215] Jennafer was denied this standard of care when her hospital refused to perform a common and low risk tubal ligation.[216] Facing the risk of experiencing a stroke at any moment, Jennafer was effectively forced to abide by *Directive* 44, which characterizes sterilizations as "intrinsically evil."[217]

CLINIC, www.mayoclinic.org/tests-procedures/tubal-ligation/basics/definition/prc-20020231 (last visited May 11, 2018).

206. *Id.* at 20.

207. *Id.*

208. *Id.*

209. *Id.*

210. *Id.*

211. Deborah Bartz & James A. Greenberg, *Sterilization in the United States*, 1 REV. OBSTETRICS & GYNECOLOGY 23, 24 (2008).

212. *Id.*

213. Am. Coll. of Obstetricians and Gynecologists, *Committee Opinion Number 530: Access to Postpartum Sterilization*, THE AM. C. OF OBSTETRICIANS & GYNECOLOGISTS (July 2012), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co530.pdf?dmc=1&ts=20170826T0330134781.

214. *Id.*

215. *Id.*

216. *See* KAYE ET AL., *supra* note 1, at 19–20.

217. DIRECTIVES, *supra* note 32, at 26.

C. Intrauterine Devices

The final story is of Melanie Jones, who suffered a condition at a young age that prevented her from using hormonal contraception.[218] Upon medical guidance, Melanie began using a copper Intrauterine Device ("IUD")—a non-hormonal contraceptive device—to prevent unintended pregnancies.[219] Using a copper IUD in place of alternative forms of birth control was necessary to reduce Melanie's risk of experiencing a stroke.[220] In late December 2015, Melanie slipped on some water in her bathroom and fell to the floor in an awkward partial split position.[221] After the fall, she began to experience cramping, pain, and heavy bleeding.[222] Believing her IUD was dislodged, Melanie made an appointment with a physician included in her insurance plan through Mercy Health Network.[223] At her appointment with Dr. Sun, Melanie received a full examination and was told that her IUD was indeed dislodged and should be removed.[224] However, Dr. Sun informed Jones that she would not be able to remove the IUD based on Mercy Health's Catholic affiliation; her '"hands [were] tied."'[225]

According to Dr. Sun, because the IUD was non-hormonal and used for the sole purpose of preventing pregnancy, Mercy Health barred any treatment related to the device.[226] Melanie asked for a referral to have the IUD removed, but Dr. Sun informed her that all of the physicians

---

218. Administrative Complaint at ¶ 23, Melanie Jones v. Mercy Hosp. & Med. Ctr., filed with U.S. Dep't of Health and Human Servs., Office for Civil Rights (June 30, 2016), https://www.aclu-il.org/sites/default/files/field_documents/melanie_jones_complaint.pdf.

219. *Id.* ¶¶ 23–24.

220. *Id.*

221. *Id.* ¶ 26; *see also Chicago Area Woman Files Complaint After Being Denied Critical Health Care Because of Religious Objections*, AM. C.L. UNION OF ILL. (Aug. 23, 2016), http://www.aclu-il.org/chicago-area-woman-files-complaint-after-being-denied-critical-health-care-because-of-religious-objections/.

222. Administrative Complaint, *supra* note 218, ¶ 26.

223. *Id.* ¶ 28.

224. *Id.* ¶ 30.

225. *Id.* ¶ 31.

226. *Id.* ¶ 33.

within her insurance network fell under the umbrella of the same Catholic restrictions.[227]

Feeling stigmatized by the experience, Melanie left the office but was not warned of the risks of further pain, bleeding, internal lacerations, scarring, and potential infection.[228] Soon after leaving, Melanie contacted an attorney who helped her expedite her insurance dilemma.[229] In order to receive the care she needed at an affordable cost, Melanie's only option was to switch insurance carriers altogether.[230] Still bleeding and in pain, Melanie was eventually able to switch networks and have the IUD removed.[231] From the time of her fall, the IUD remained partially dislodged from Melanie's uterus for a total of ten days before it was finally extracted.[232]

Melanie's situation presents another Catholic deviation from the standard of medical care, while highlighting a true deficit in access to reproductive medicine under the *Directives*. IUD expulsion is common during the first-year of a woman's IUD use.[233] When a copper IUD is dislodged, it becomes less effective at preventing pregnancy.[234] Importantly, causing a delay in removing an expelled IUD not only exposes the woman to medical risks, but limits her lifestyle choices. Treatment for a partially expelled IUD is a simple outpatient procedure where the device is removed with forceps.[235] Melanie received this exact care upon seeking treatment at a non-Catholic facility.[236] When Melanie's IUD was eventually removed, she was advised not to replace it right away because the delay in treatment caused an increased risk of

227. *Id.* ¶ 34.
228. *Id.* ¶ 35.
229. *Id.* ¶¶ 37–40.
230. *Id.* ¶ 34.
231. *Id.* ¶¶ 37–42.
232. *Id.* ¶¶ 26–42.
233. THE CAPACITY PROJECT, U.S. AGENCY FOR INT'L DEV., IUD GUIDELINES FOR FAMILY PLANNING SERVICE PROGRAMS: A PROBLEM-SOLVING REFERENCE MANUAL 1–5 (Julia Bluestone, Rebecca Chasse & Enriquito R. Lu eds., 3d ed. 2006), reprolineplus.org/system/files/resources/iud_manual_0.pdf.
234. Kristina M. Nowitzki, *Ultrasonography of Intrauterine Devices*, 34 ULTRASONOGRAPHY 183, 190–91 (July 2015).
235. *Id.* at 191; *see also* THE CAPACITY PROJECT, *supra* note 233.
236. *See generally* Administrative Complaint, *supra* note 218.

laceration and scarring.[237] Unable to use hormones, Mercy Health Network was able to prevent Melanie from using an effective form of birth control. If Melanie had lacked the means to contact an attorney, she would have been forced to wait at least one month to have the device removed.[238] With insurance networks shrinking consumers' choice in physician,[239] reduced access to reproductive services caused by the *Directives* is becoming a tangible problem.

Outside the context of religion, physicians and hospitals are held accountable for their actions. Courts have held physicians liable for malpractice for failure to disclose the risks associated IUD related complications.[240] In *Williams v. Golden*, a woman became pregnant while using an IUD.[241] The physician failed to disclose that the continued use of an IUD while pregnant risks infection, spontaneous abortion, and premature delivery.[242] The physician was held liable after the patient developed an infection that resulted in PROM and the preterm delivery of her child.[243] However, Catholic hospitals are not being held accountable for failures to disclose patient conditions governed by the *Directives*. Hiding behind a religious shield, the reach of Catholic hospitals is expanding and ultimately limiting access to reproductive services.

Religious shields come in the form of conscience clause legislation. In the wake of *Roe v. Wade,*[244] Congress enacted the Church Amendment.[245] This conscience clause exempts government funded

---

237. *Id.* ¶¶ 43–44.

238. *Id.*

239. *See* Justin Glovannelli et al., *Health Policy Brief: Regulation of Health Plan Provider Networks*, HEALTH AFF. 1–2 (July 28, 2016), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_160.pdf.

240. Williams v. Golden, 699 So. 2d 102, 112–13 (La. Ct. App. 1997), *cert. denied*, 709 So. 2d 708 (La. 1998); Canesi *ex rel.* Canesi v. Wilson, 730 A.2d 805, 818 (N.J. 1999) (explaining that a physician's inadequate disclosure was enough to support proximate cause and ultimately, liability for injuries to the patient and her child).

241. *Golden*, 699 So. 2d at 112–13.

242. *Id.*

243. *Id.*

244. Roe v. Wade, 410 U.S. 113 (1973).

245. Elizabeth Sepper, *Taking Conscience Seriously*, 98 VA. L. REV. 1501, 1507 (2012) [hereinafter *Taking Conscience Seriously*].

entities from performing abortions and sterilizations on the basis of religion, allowing entire hospitals to refuse these services.[246] Almost all states now have some form of conscience clause legislation.[247] As discussed further below, these conscience clauses disregard the conscience of individual physicians who want to provide women with sound reproductive services.[248] Yet, the Church Amendment lays out far-reaching protections to those unwilling to perform or assist in a "program or activity [that] would be contrary to his religious beliefs or morals."[249] There are many valid arguments for providing protections to individuals who refuse to provide certain services.[250] However, problems arise when entire organizations are exempt from discriminating against medical staff who are willing to provide those same services.[251] After all, it may be against a physician's religious beliefs or moral to lie to a patient regarding their diagnosis.

Conscience clause legislation and hospital mergers have been recognized as societal issues for decades.[252] However, the specific contractual provisions behind these agreements have been under-studied in legal literature. Provisions enforcing the *Directives* must be tested against conscience clause legislation considering the result of these provisions puts women's physical well-being in jeopardy.

IV. CONTRACTUAL OBLIGATIONS, ILLEGALITY, AND BALANCING INDIVIDUAL INTERESTS

A contractual term may be deemed unenforceable for illegality based on contrary legislation or for reasons of public policy.[253] At

246. 42 U.S.C. § 300a-7 (2006).

247. *Taking Conscience Seriously*, *supra* note 245, at 1504; *see also* Claire Marshall, *The Spread of Conscience Clause Legislation*, 39 RELIGIOUS FREEDOM (2013).

248. *Taking Conscience Seriously*, *supra* note 245, at 1503, 1518.

249. 42 U.S.C. § 300a-7.

250. The argument reverses once you deny an individual the right to refuse to carry out a procedure that conflicts with his or her religious beliefs.

251. *See generally Taking Conscience Seriously*, *supra* note 245.

252. *See generally id*.; Ikemoto, *supra* note 27.

253. RESTATEMENT (SECOND) OF CONTRACTS § 178 (AM. LAW INST. 1981); *see also* Martello v. Santana, 713 F.3d 309, 313 (6th Cir. 2013) (explaining that prohibitions against provisions in Kentucky's Rules of Professional Conduct could be held by the court to violate public policy); Cain v. Darby Borough, 7 F.3d 377, 382

times, these two bases for argument overlap because courts may analyze the public policy reasoning behind the contrary legislation at issue.[254] A court can also simply hold that agreements contrary to legislation are contrary to public policy.[255] Thus, the various arguments below may be set forth independently or in conjunction with each other, depending on the context. Regardless, agreements between hospitals that bar certain procedures and prohibit physicians from fully informing their patients are unenforceable under current legislation and for reasons of public policy.

A. Void as a Matter of Contrary Legislation

Finding hospital merger agreements void on the basis of legislation can protect the physical health and safety of individuals. Both federal and state courts have held contractual provisions as unenforceable when they violate federal law and are thus illegal. Furthermore, many state statutes hold contracts illegal or unlawful when they contradict established provisions of state law.[256] Safeguarding legislation that protects peoples' physical health and safety from contracts adhering to the *Directives* should be of the utmost concern to society.

1. The Emergency Medical Treatment and Labor Act

The Emergency Medical Treatment and Labor Act ("EMTALA") is a federal statute mandating hospital emergency departments to

---

(3d Cir. 1993), *cert. denied*, 510 U.S. 1195 (1994) (explaining that a release-dismissal agreement with police that surrendered a plaintiff's civil rights was unenforceable as against public policy); Shadis v. Beal, 685 F.2d 824, 833 (3d Cir. 1982), *cert. denied*, 459 U.S. 970 (1982) (holding that a contractual term that contravened a federal statute required "only an adequate declaration of public policy inconsistent with the contract terms to render the contract unenforceable."); *In re* Marriage of Cauley, 41 Cal. Rptr. 3d 902, 906 (Cal. Ct. App. 2006) (holding a non-modifiable spousal-support provision unenforceable as against public policy where the supported spouse had engaged in multiple acts of domestic violence); Blossom Farm Prods. Co. v. Kasson Cheese Co., 395 N.W.2d 619, 623 (Wis. 1986) (rendering a transaction unenforceable where illegal additives were added to a product and were omitted from the product label).

254. *See generally* RESTATEMENT (SECOND) OF CONTRACTS § 178.

255. Kohn v. Sch. Dist. of Harrisburg, 817 F. Supp. 2d 487, 501 (M.D. Pa. 2011).

256. *See, e.g.*, N.D. CENT. CODE ANN. § 9-08-01 (West 2017); OKLA. STAT. ANN. tit. 15, § 211 (West 2017); S.D. CODIFIED LAWS § 53-9-1 (2017).

medically assess any individual who requests treatment for a medical condition, regardless of their ability to pay.[257] If indicated by the patient's condition, the hospital must also provide stabilizing treatment in emergent situations.[258] Patients who require emergent and stabilizing treatment that contradict the *Directives* must receive treatment under this federal law.[259] This was precisely the case with Tamesha Means when she was diagnosed with preterm PROM. Under EMTALA, Mercy Health was required to stabilize Tamesha, but sent her home instead.[260] When Tamesha returned for the second time and her physician discovered the presence of a life-threatening infection, she was sent home again,[261] in direct violation of EMTALA.[262] Finally, Mercy Health tried to send Tamesha home a third time just before she began to deliver.[263] The two instances in which Mercy sent Tamesha home are violations of federal law, because the hospital was obligated to stabilize her condition of preterm PROM under EMTALA.[264]

Although state legislation exists that allows for religious hospitals to provide less than the standard of care, EMTALA is explicit in that contradictory state law cannot preempt its requirements.[265] This establishes a strong interest of the federal government to provide access to emergent medical care regardless of a patient's medical condition or ability to pay. The emphasis is on human life versus money or property. In *McBrearty v. United States Taxpayers Union*, a contract was held to be void because it "encouraged violations of federal tax laws."[266]

257. 42 U.S.C. § 1395dd (2012).

258. *Id.*

259. *Id.*

260. *See generally id.*

261. Means v. United States Conference of Catholic Bishops, 836 F.3d 643, 647 (6th Cir. 2016).

262. Considering the infection threatened Means's life, the hospital had an obligation to stabilize her condition under EMTALA.

263. *Means*, 836 F.3d at 643.

264. EMTALA requires patients to be stabilized before transfer. 42 U.S.C. § 1395dd(c)(1) (2012). Discharging a patient home constitutes a transfer under the law. *Id.* at § 1395dd(e)(4).

265. *Id.* § 1395dd(f) (explaining that EMTALA preempts state laws that directly conflict with its provisions); *see also* U.S. CONST. art. VI, cl. 2 (stating that laws made under the authority of the United States "shall be the supreme Law of the Land . . . .").

266. McBrearty v. U.S. Taxpayers Union, 668 F.2d 450, 451 (8th Cir. 1982).

Seeing that a violation of EMTALA puts a patient's physical health in danger, a contractual provision that not only encourages but requires its violation should surely be deemed illegal. Therefore, federal legislation should render void contractual provisions limiting emergent medical treatment based on the *Directives*.

While raising violations of EMTALA appears to be a viable option, this argument is limited. Stabilizing a patient does not automatically make them healthy or free them from the burden of traveling to a different hospital for additional (but non-emergent) treatment. For example, tubal ligations are considered an elective procedure,[267] meaning that many of the patient stories described in this comment would result in the same outcome, regardless of federal law. Thus, additional challenges are posed below.

2. Antitrust Law and the Federal Trade Commission Act

Another issue that arises in the context of hospital mergers is whether the merger is permitted under Antitrust legislation. Although the issue of binding secular organizations to Catholic *Directives* has not been directly decided, statements from the Federal Trade Commission ("FTC") shed light on an analogous situation.

In 2010, Medical Examiners in Alabama attempted to enact a law that would restrict certified registered nurse anesthetists ("CRNAs") from performing certain pain management procedures.[268] The legislature cited public safety as a reason for enactment, but the Board of Nursing deemed CRNAs qualified to perform these procedures based on their education and certification.[269] The FTC wrote a letter to the Medical Examiners that opposed the projected legislation.[270] The letter stated that CRNAs providing these services did not present an issue of public safety, and that the law should not restrict certified healthcare professionals from performing treatments within their scope of

---

267. *See generally Sterilization by Laparoscopy*, THE AM. C. OF OBSTETRICIANS & GYNECOLOGISTS (May 2016), https://www.acog.org/-/media/For-Patients/faq035.pdf?dmc=1&ts=20170827T2101117520.

268. NICOLE HUBERFELD ET AL., THE LAW OF AMERICAN HEALTHCARE 437 (2017).

269. *Id.*

270. *Id.*

practice.[271] Additionally, the FTC noted that the law would ultimately hurt consumers by reducing access to anesthetic medicine and innovation, while increasing prices.[272] The Medical Board denied the proposed legislation in response to the FTC.[273]

Restricting a physician's ability to practice medicine when it comes to reproductive rights is analogous to restricting CRNAs from administering certain treatments. Like the CRNAs, physicians at Catholic hospitals are being restricted from providing care that is within their scope of practice. By reducing the number of physicians that can perform these services, access to them decreases, while demand and cost increase. Meanwhile, innovation in technology and medicine will be stifled because fewer physicians will be providing these services and those who remain will have no incentive to change current procedures.

Forcing secular hospitals to abide by the *Directives* appears to be in direct conflict with the Federal Trade Commission Act ("FTCA"), 15 U.S.C. § 45.[274] Section (a)(1) of the FTCA states, "Unfair methods of competition . . . and unfair or deceptive acts or practices in or affecting commerce, are hereby declared unlawful."[275] Contractual provisions binding secular hospitals to the *Directives* are unfair because, as discussed above, the *Directives* are subject to change. Since the first set of *Directives* were released in 1921, the USCCB has issued increasingly strict editions in terms of limiting reproductive care.[276] And even if the *Directives* were to remain consistent on paper, local Bishops have the final say when interpreting them.[277] Certain Bishops may be stricter than others and local community Bishops change over time.[278] Non-Catholic organizations may not actually know what they agreed to until the Bishop governing that agreement begins interpreting

---

271. *Id.*

272. *Id.* at 438.

273. Press Release, Am. Soc'y of Interventional Pain Physicians, Leading Doctors' Society Objects to Ala. Med. Bd.'s Decision to Delay Restrictions on Improper Practice of Pain Treatments (Nov. 2010), https://nanopdf.com/download/draft-for-review-american-society-of-interventional-pain-physicians_pdf.

274. *See generally* 15 U.S.C. § 45 (2012).

275. *Id.*

276. *See generally* O'Rourke et al., *supra* note 40.

277. *See* HEALTH CARE COMPROMISED, *supra* note 28, at 21.

278. *Id.*

the *Directives*.[279] Generally, contractual modifications are not permitted unless the circumstances call for it,[280] which implies that these continually changing contracts are unfair under current law. Furthermore, increased bargaining power can constitute a procedural unfairness factor when entering into contracts.[281] As mentioned above, Catholic hospitals may have increased bargaining power when negotiating with secular hospitals through 501(c)(3) tax-exempt status.

Merger contracts that require adherence to the *Directives* are affecting commerce by limiting access to facilities that are willing to provide women with reproductive services. This reduction results in longer waiting periods, increased travel time, and ultimately, higher costs.[282] Based on the Catholic Church's opposition to many women's reproductive healthcare services, Catholic hospitals may be attempting to reduce competition by eliminating certain services altogether. Not only does this practice impact commerce, but it is unfair to non-Catholic organizations that wish to provide these services. Violations of both the FTCA and EMTALA are controlled by federal law, establishing that these contractual provisions should be void based on contrary legislation.[283]

B. Void as a Matter of Public Policy

Another way to challenge these contractual provisions is by weighing public policy concerns against arguments that call for enforcing contractual obligations.[284] The United States values the freedom of contract formation and the ability of citizens to enter into

279. *See generally id.*

280. *See* 3 WILLISTON ON CONTRACTS § 7:37 (4th ed. 2017).

281. *See* 8 WILLISTON ON CONTRACTS § 18:10 (4th ed. 2017).

282. *See Abortion Restrictions Put Women's Health Safety and Wellbeing at Risk*, BIXY CTR. FOR GLOBAL REPROD. HEALTH, https://bixbycenter.ucsf.edu/sites/bixbycenter.ucsf.edu/files/Abortion%20restrictions%20risk%20women%27s%20health.pdf (last visited May 11, 2018).

283. *See* Kaiser Steel Corp. v. Mullins, 455 U.S. 72, 77 (1982) (In determining whether a contract was void for illegality, the Supreme Court held that "illegal promises will not be enforced in cases controlled by federal law.").

284. RESTATEMENT (SECOND) OF CONTRACTS § 178 (AM. LAW INST. 1981).

binding agreements at their own will.[285] Enforcement of contractual obligations have been upheld even when terms are deemed unfair or disproportionate.[286] Permitting enforcement of these contracts is embedded in the concept of the "bargain principle," where courts will enforce an agreement based on its terms,[287] but not on the fairness of those terms. Although freedom of contract is an important and necessary right, policy concerns regarding public health and safety may outweigh this right.

In *Tunkl v. Regents of University of California*, the plaintiff challenged the enforceability of an exculpatory clause that limited physician liability for negligence.[288] The term was a condition for being admitted as a patient through a charitable research hospital.[289] Holding the clause unenforceable,[290] the court found the determination to be one of public interest because it did not solely affect private parties.[291] Emphasis was placed on the fact that individual citizens are "completely dependent upon the responsibilities of others" when it comes to the "performance of the high standards of hospital practice."[292] It was further noted that a hospital-patient contract "clearly [fell] within the category of agreements affecting the public interest."[293] Although the contract was between a patient and the provider instead of two entities, the court's reasoning is still applicable.

Contractual provisions enforcing the *Directives* affect public interest because they forfeit the rights of many healthcare consumers.

---

285. *See* Beacon Hill Civic Ass'n v. Ristorante Toscano, Inc., 662 N.E.2d 1015, 1017 (Mass. 1996) (holding that the general rule is to allow for the freedom of contract); *see also* Baugh v. Novak, 340 S.W.3d 372, 383 (Tenn. 2011).

286. *See* Hancock Bank & Trust Co. v. Shell Oil Co., 309 N.E.2d 482, 483 (Mass. 1974) (holding that a fifteen-year negotiated lease with a flat rate and the option to terminate at any time with ninety days' notice was an enforceable bargain despite the one-sided terms); Batsakis v. Demotsis, 226 S.W.2d 673, 674–75 (Tex. Civ. App. 1949) (upholding a bargain where 500,000 drachmas, valued at $25, was exchanged for a promise to pay $2,000 at a later date).

287. Melvin Aron Eisenberg, *The Bargain Principle and Its Limits*, 95 HARV. L. REV. 741, 742 (1982).

288. Tunkl v. Regents of Univ. of Cal., 383 P.2d 441, 441–42 (Cal. 1963).

289. *Id.* at 442.

290. *Id.* at 448–49.

291. *Id.* at 447.

292. *Id.* at 448.

293. *Id.* at 447.

Women come to these hospitals dependent on physicians to give them all the reasonable information about their health. The defendants in *Tunkl* argued that because it was a charitable organization (that accepted only certain patients), the clause should not have been invalidated.[294] The court disagreed and found it "abhorrent to medical ethics as it is to legal principle" to invalidate the clause on this basis.[295] It was further noted that the hospital held itself out as willing to perform services for members of the public.[296] In cases involving the *Directives*, women may not know that the hospital does not provide certain services or that, depending on their location and resources, they may have no other choice of provider. All the while, Catholic hospitals are held out as facilities that provide medical services to the public.

The policy arguments offered and outlined below may provide valuable data for a plaintiff arguing the unenforceability of contractual obligations binding facilities to the *Directives*.

1. The Separation of Church and State

The concept of the separation of church and state can be traced back to the Establishment Clause of the United States Constitution.[297] In 1802, Thomas Jefferson wrote to the Danbury Baptists reiterating that the legislature should "make no law respecting an establishment of religion or prohibiting the free exercise thereof."[298] This built a wall of separation between church and state. Today, however, the federal government appears to be fueling the rise of Catholic hospitals throughout the United States. Not only did these hospitals receive "$27 billion in net revenue" through Medicare and Medicaid programs in 2011, but they also benefit from massive tax breaks through 501(c)(3) exemption status.[299] This status can be obtained by organizations that use it solely for religious purposes,[300] and as discussed above,

294. *Id.* at 448.
295. *Id.*
296. *Id.* at 444–47.
297. U.S. CONST. amend. I.
298. Letter from Thomas Jefferson, to Nehemiah Dodge, Ephraim Robbins & Stephen S. Nelson, a Comm. of the Danbury Baptist Ass'n in Conn. (Jan. 1, 1802), http://www.loc.gov/loc/lcib/9806/danpre.html.
299. HEALTH CARE COMPROMISED, *supra* note 28, at 5.
300. I.R.C. § 501(c)(3) (2012).

additional religious exemptions exist through Conscience Clause legislation.[301] As illustrated in the women's stories throughout this comment, this legislation has gone too far. Allowing physicians to decline to perform services they find unethical is generally viewed as appropriate and within their rights. However, to exempt entire organizations based on overarching religious objections forces religious beliefs onto individuals governed by hospital policies.[302]

The power of the Catholic Church is visible through lobbying efforts made by the Catholic Health Association ("CHA") and USCCB.[303] Both of these groups—which qualify for 501(c)(3) exemption status—put forth large sums of money through lobbying.[304] For example, in an effort to influence federal legislation with policies favorable to the Church, the CHA spent over $5 million in 2013 and the USCCB reported spending $108 million in 2014.[305] Also in 2014, the USCCB spent "78 percent of . . . [its] operating fund" advocating anti-choice policy alone.[306] The primary objective of the USCCB appears to be suppressing women's free choice and their legal right to have an abortion. The financial and legal flexibilities allotted to the Catholic Church resulting from this extensive lobbying are apparent through religious tax-exempt status and Conscience Clause legislation.

Forcing religious doctrines onto unwilling consumers and physicians infringes on the rights of the millions of non-Catholic individuals who receive care from Catholic hospitals every year. This infringement is extremely personal in that it limits, and in some cases eliminates, an individual's decision-making power when it comes to their own physical well-being. Blanket religious exemptions in the healthcare setting violates the right to privacy and the free exercise of other religions in terms of healthcare decision-making.

301. *See* 42 U.S.C. § 300a-7 (2006); *Taking Conscience Seriously*, *supra* note 245, at 1501, 1507.

302. *Taking Conscience Seriously*, *supra* note 245, at 1503–04.

303. HEALTH CARE COMPROMISED, *supra* note 28, at 15.

304. *Id.*

305. *Id.*

306. *Id.*

2. Privacy and the Integrity of the U.S. Healthcare System

A unique feature of healthcare that distinguishes it from many other industries is the principle of privacy. Patients are afforded privacy in making medical decisions, encouraging them to be open and honest with their physicians, and ultimately, avoid adverse outcomes. Seemingly harmless medications could result in death depending on a patient's history.[307] To achieve a trusting relationship between doctors and patients, there must be an expectation of privacy.[308] While a limited number of situations may call for disclosure,[309] legislators and the Supreme Court have emphasized the importance of privacy in the medical field.[310]

The decision in *Roe v. Wade*—where abortion was effectively decriminalized—was premised on the idea that a woman's right to terminate her pregnancy is encompassed in the fundamental and constitutional right to privacy.[311] While this right is not absolute, state interests focus on women's safety, medical standards of care, and the preservation of life as the limiting factors for a states' ability to regulate abortions.[312] As established above, medical standards of care and women's health are being jeopardized under the *Directives*. Moreover, the preservation of life is just one of the three state interests listed in *Roe v. Wade* and given the fact that women's lives are being put at risk, the Catholic Church can hardly argue that the *Directives* serve to preserve life in this context. Furthermore, *Roe v. Wade* focused on state

307. *Acetaminophen and Liver Injury: Q & A for Consumers*, U.S. FOOD & DRUG ADMIN. (June 24, 2009), https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm168830.htm (explaining that someone with liver damage has an increased risk of liver failure from taking the over-the-counter pain reliever, Tylenol).

308. Susan Dorr Goold & Mack Lipkin, *The Doctor–Patient Relationship: Challenges, Opportunities, and Strategies*, 14 J. GEN. INTERNAL MED. S26, S26 (Jan. Supp. I 1999) (discussing how a patient may not disclose all of their health information if they do not trust their physician).

309. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., SUMMARY OF THE HIPAA PRIVACY RULE 4–5 (2003) (describing situations including but not limited to: emergencies, state law requirements, insurance disclosures, and specific situations of abuse).

310. *See* Roe v. Wade, 410 U.S. 113, 153 (1973).

311. *Id.* at 154.

312. *Id.*

interests, and taking into account the different healthcare needs of people within our society, Catholic ideology is not representative of entire states. The USCCB—the organization that releases the *Directives*—is one group composed of 315 people, headquartered in Washington D.C.[313] This group uses its influence to promote Catholic ideals in legislation, thereby effectively making private medical decisions for women across the nation.

The *Directives* require physicians to breach their fiduciary duties to patients, enabling them to provide less than the requisite standard of care for certain services.[314] Considering that patients often know very little about their healthcare, many women will never know the *Directives* caused the complications they suffered.[315] One of the major drawbacks to this is that as more information on this issue emerges, people will lose faith in the healthcare system. The expectation of trust between physicians and patients will be a thing of the past if the current trend of eliminating services is allowed to progress.

Without privacy, discrimination manifests itself throughout society, as has been seen in the context of race, sexuality, socioeconomics, and age.[316] As previously noted, despite the holding in *Roe v. Wade*, legislation restricting reproductive rights was enacted.[317] The Supreme Court decisions that followed may have set the stage for dangerous precedent. For example, in *Harris v. McRae*, the plaintiffs challenged the Hyde Amendment's limitations on the use of federal funds to reimburse medically necessary abortions under Medicaid.[318] Among other constitutional challenges, the law was found

313. *About USCCB*, *supra* note 38.

314. *See* DIRECTIVES, *supra* note 32, at 26–27, 37 (*Directives* 45, 48, 53, and 70 limit a physician's abilities to carry out medically necessary procedures, and to advise competently on methods of contraception).

315. *See* Redden, *supra* note 171.

316. *See generally Addressing Disparities in Reproductive and Sexual Health Care in the U.S.*, CTR. FOR REPROD. RTS., https://www.reproductiverights.org/node/861 (last visited May 11, 2018); *see also* Ian Millhiser, *Bishops Freak Out After Catholic Hospitals Consider Giving Equal Rights to Gay People*, THINK PROGRESS (Jan. 26, 2015, 6:31 PM), https://thinkprogress.org/bishops-freak-out-after-catholic-hospitals-consider-giving-equal-rights-to-gay-people-ee01d9c24cd2.

317. *Taking Conscience Seriously*, *supra* note 245, at 1507.

318. Harris v. McRae, 448 U.S. 297, 301 (1980).

to be valid under the constitutional guarantee of equal protection.[319] The problem with this is that, considering innovations in healthcare that show predisposition to diseases,[320] allowing specific services to be excluded under Medicaid could allow for indirect discrimination. Certain races, ethnicities, and sexes hold higher risks for specific diseases.[321] Diseases primarily effecting one or two classes of people could be excluded from reimbursement given this precedent. Women's health issues have already been targeted. Women's rights are human rights, and if reproductive rights are further diminished, other human rights will most certainly follow.

3. The Impact of Reproductive Rights on Crime

Another policy issue arises when evaluating the data linking legalized abortion to reductions in crime.[322] Findings suggest that the legalization of abortion is linked to decreased crime rates within the United States.[323] One explanation for this data is based on the idea that women who seek abortions often live in suboptimal conditions for raising a child, as many of these women are teenagers, single mothers, below the poverty line, etc.[324] A reduction in crime rates was found in those children born after the landmark decision in *Roe v. Wade*.[325] Meanwhile, those children born prior to the decision showed little change in regard to criminal activity.[326] Furthermore, legalized abortion reduces the number of infants born into impoverished households; a factor that increases a child's risk for engaging in criminal activity later in life.[327] This data could be useful to policy makers, considering the

---

319. *Id.* at 323.

320. *See, e.g.*, *Race and Ethnicity: Clues to Your Heart Disease Risk?*, HARV. HEALTH PUB. (July 17, 2015), http://www.health.harvard.edu/heart-health/race-and-ethnicity-clues-to-your-heart-disease-risk.

321. *Id.*

322. *See generally* John J. Donohue III & Steven D. Levitt, *The Impact of Legalized Abortion on Crime*, 116 Q. J. ECON. 379 (May 2001).

323. *Id.* at 381.

324. *Id.*

325. *Id.* at 382.

326. *Id.*

327. *See id.* at 387.

United States has one of the highest rates of infant mortality of all developed countries.[328]

Ultimately, those who advocate for the life of the unborn may mistakenly assume that the potential life of the fetus will in fact, turn out to be a good life. Recognized findings support the idea that giving women the right to choose impacts society in a positive way.[329] Reducing criminal activity within the United States is a large concern when it comes to policy and the criminal justice system.[330] Bearing in mind that "[s]ince 2002, the United States has [had] the highest incarceration rate in the world"[331] and the effect of deterrence is thought to be minimal,[332] factors such as abortion should be explored. As the current and past political climates indicate, the issue of abortion is controversial and uncomfortable to many. Therefore, issues surrounding abortion should not be evaluated lightly. However, this issue must be discussed and evaluated despite discomfort in order to ensure the best outcome for women and society as a whole.

4. Financial Benefits of Family Planning Programs

Having women in the workforce tremendously impacts the economy, and access to birth control increases the number of women in the workforce who are of reproductive age.[333] However, according to *Directive* 52, Catholic hospitals can only counsel women on natural

328. HUBERFELD ET AL., *supra* note 268, at 2.

329. *See* Donohue & Levitt, *supra* note 322, at 382.

330. LAW ENFORCEMENT LEADERS TO REDUCE CRIME & INCARCERATION, FIGHTING CRIME AND STRENGTHENING CRIMINAL JUSTICE: AN AGENDA FOR THE NEW ADMINISTRATION 1 (2017); Inimai Chettiar, *A National Agenda to Reduce Mass Incarceration*, *in* SOLUTIONS: AMERICAN LEADERS SPEAK OUT ON CRIMINAL JUSTICE 123 (Inimai Chettiar & Michael Waldman eds., 2015), https://www.brennancenter.org/sites/default/files/publications/Solutions_American_Leaders_Speak_Out.pdf.

331. Tyjen Tsai & Paola Scommegna, *U.S. Has World's Highest Incarceration Rate*, POPULATION REFERENCE BUREAU (Aug. 2012), http://www.prb.org/Publications/Articles/2012/us-incarceration.aspx.

332. *Five Things About Deterrence*, NAT'L INST. OF JUST. (May 2016), https://www.ncjrs.gov/pdffiles1/nij/247350.pdf.

333. *See generally* JOANNA BARSH & LAREINA YEE, UNLOCKING THE FULL POTENTIAL OF WOMEN AT WORK (2012).

family planning services.[334] This creates a material disparity in counseling services because "more than 99% of women aged 15–44 who have ever" been sexually active "have used at least one contraceptive method."[335] For Catholic women of child-bearing age, just 2 percent rely on natural family planning as a form of birth control.[336] Furthermore, investing in family planning programs like Planned Parenthood saved the federal government $13.6 billion in 2010.[337] For every $1 of public money the government spent on these services, it saved $7.09.[338] Preventative reproductive services help women avoid suffering the disabling costs associated with unintended pregnancies. Facilities such as Planned Parenthood also prevent costly diseases such as cervical cancer and HIV by providing access to early screening.[339] Abortion has grown to be such a polarizing issue within our society that many pro-life advocates choose not to see the positive impact that facilities such as Planned Parenthood have throughout the country.

In 2014, the Congressional budget report conceded that the Title X Family Planning Program was "moderately effective."[340] This is significant considering only a fraction of funding was distributed to Title X Family Planning compared to the other healthcare programs

---

334. DIRECTIVES, *supra* note 32, at 27; *see also What Is Natural Family Planning?*, U.S. CONF. OF CATH. BISHOPS, http://www.usccb.org/issues-and-action/marriage-and-family/natural-family-planning/what-is-nfp/ (last visited May 11, 2018) (Natural family planning is a method of attempting to prevent pregnancy by observing "naturally occurring signs and symptoms of the fertile and infertile phases of a woman's menstrual cycle" without the use of medications, devices, or surgical procedures).

335. *Fact Sheet: Contraceptive Use in the United States*, GUTTMACHER INST. (Sept. 2016), https://www.guttmacher.org/sites/default/files/factsheet/fb_contr_use_0.pdf.

336. *Id.*

337. *See* Jennifer J. Frost et al., *Return of Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program*, 92 MILBANK Q. 667, 703 (2014).

338. *Id.*

339. Tara Culp-Ressler, *U.S. Taxpayers Save $7 For Every Dollar the Government Spends on Family Planning*, THINK PROGRESS (Oct. 15, 2014, 1:32 PM), https://thinkprogress.org/u-s-taxpayers-save-7-for-every-dollar-the-government-spends-on-family-planning-8eb5c609401f.

340. HOUSE BUDGET COMMITTEE, THE WAR ON POVERTY: 50 YEARS LATER: A HOUSE BUDGET COMMITTEE REPORT 122 (2014).

described in the report.[341] Despite these findings, Congress and the Executive Branch are making efforts to defund Planned Parenthood;[342] a program that delivers reproductive healthcare and family planning education to "nearly five million women, men, and adolescents worldwide in a single year."[343] Just within the United States, 2.4 million men and women visit Planned Parenthood annually.[344]

Based on the rising costs of healthcare in the United States,[345] these efforts appear fiscally unsound and irresponsible. The healthcare industry makes up nearly 20 percent of the United States economy, and in 2016, spending on healthcare exceeded $3.4 trillion.[346] Pulling funding from effective preventative programs will only fuel these rising costs in the long-run.

Additional financial (and environmental) concerns surround the issue of over-population.[347] The earth has limited resources and the United States population continues to consume them disproportionately.[348] Pressuring women to have children against their will through legislation only adds to this problem. Famous scientist, Bill Nye the "Science Guy," proposed controlling the population by empowering women.[349] Giving women freedom and choice in their reproductive medicine allows them to make intelligent decisions when

---

341. *Id*. at 113, 115, 117, 119, 121–22.

342. *See* Defund Planned Parenthood Act of 2017, H.R. 354, 115th Cong. (2017).

343. *Planned Parenthood at a Glance*, PLANNED PARENTHOOD, https://www.plannedparenthood.org/about-us/who-we-are/planned-parenthood-at-a-glance (last visited Aug. 29, 2017).

344. *Id.*

345. HUBERFELD ET AL., *supra* note 268, at 1 (describing the $1.5 trillion gap in healthcare spending between the United States and other developed counties).

346. *Id.*

347. *See The United States is Already Overpopulated*, FED'N FOR AM. IMMIGR. REFORM (Sept. 2009), http://www.fairus.org/issue/the-united-states-is-already-overpopulated; George Gao, *Scientists More Worried Than Public About World's Growing Population*, PEW RES. CTR. (June 8, 2015), http://www.pewresearch.org/fact-tank/2015/06/08/scientists-more-worried-than-public-about-worlds-growing-population/.

348. BILL NYE SAVES THE WORLD: EARTH'S PEOPLE PROBLEM (Netflix 2017).

349. *Id.*

it comes to family planning.[350] A single mother may not have the necessary resources to provide for an additional child, leaving state and federal governments to provide for them. Based on personal goals and her position in life, the woman herself is in the best position to decide whether having a child is the right decision for her. There are times when birth control fails or women, being human, use it ineffectively or not at all. In these instances, the woman did not set out to become pregnant so that she could have an abortion but terminating the pregnancy may be the best option for her and society as a whole. The concept of guilting a woman into having a child disregards the personal freedoms in which this country was founded on, especially considering the impact pregnancy and/or mothering will have on a woman's health and future. As described below, pulling or defunding reproductive services may also endanger the lives of women who wish to carry their pregnancy to term.

5. Protecting Women

The Supreme Court has used protecting women's health and safety as a reason to regulate abortion rights.[351] Yet, research shows that carrying a child to term is more dangerous than undergoing a legal abortion.[352] One study showed that 3 women out of every 1,000,000 died from an abortion performed at less than eight weeks.[353] Even late-term abortions that may have been medically necessary only rose to 67 of every 1,000,000.[354] Other studies show similar results.[355] The

350. *Family Planning: Strategy Overview*, BILL &MELINDA GATES FOUND., http://www.gatesfoundation.org/What-We-Do/Global-Development/Family-Planning (last visited May 11, 2018).

351. Roe v. Wade, 410 U.S. 113, 154 (1973).

352. *See* Suzanne Zane et al., *Abortion-Related Mortality in the United States 1998–2010*, 126 OBSTETRICS & GYNECOLOGY 258, 258 (2015); *Health-Related SDGs*, INST. FOR METRICS AND EVALUATION (2016) [hereinafter *Health-Related SDGs*], http://vizhub.healthdata.org/sdg/.

353. Zane, *supra* note 352, at 258.

354. *Id.*

355. *See* Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 OBSTETRICS & GYNECOLOGY 175, 181–82 (2015).

maternal death rate[356] in the United States is much higher, listed at 251 per 1,000,000 in 2015.[357] This rose from 171 in 2000.[358] Despite these alarming statistics, the *Directives* still lists abortion as an "intrinsically evil" procedure though safer than carrying a child to term.[359]

The World Health Organization has recognized maternal deaths as an international issue and is focusing on decreasing fatalities of pregnant women across the globe.[360] Every day, approximately "830 women die from pregnancy or child-birth related complications around the world."[361] Ninety-nine percent of these deaths take place in developed countries.[362] From 1990 to 2015, maternal fatalities declined by 44 percent globally.[363] However, as stated above, maternal deaths within the United States are rising.[364] For Texas in particular, maternal death rates actually doubled from 2011 through 2012.[365] During these years, women's health services underwent many changes.[366] New laws shut down women's clinics, and the state cut two-thirds of the family planning budget,[367] while excluding "Planned Parenthood affiliates

356. Maternal death rates measure how many women die "while pregnant or within 42 days of termination of pregnancy. . . from any cause related to or aggravated by, but not from accidental or incidental causes." *Maternal Mortality: Fact Sheet*, WORLD HEALTH ORG., http://www.who.int/mediacentre/factsheets/fs348/en/ (last updated Nov. 2016) [hereinafter *Maternal Mortality*].

357. *Health-Related SDGs*, *supra* note 352.

358. Michael Ollove, *The US is an Outlier: Maternal Mortality Rates Rise Since 2000*, PEW RES. CTR. (Sept. 23, 2016), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/09/23/the-us-is-an-outlier-maternal-mortality-rates-rise-since-2000.

359. DIRECTIVES, *supra* note 32, at 42.

360. *Maternal Mortality: Fact Sheet*, *supra* note 356.

361. *Id.*

362. *Id.*

363. *Id.*

364. Marion F. MacDorman et al., *Is the United States Maternal Mortality Rate Increasing? Disentangling Trends From Measurement Issues*, 128 OBSTETRICS & GYNECOLOGY 447, 453 (2016).

365. *Id.* at 453–54.

366. MacDorman et al., *supra* note 364, at 453.

367. Alexandra Sifferlin, *Why U.S. Women Still Die During Childbirth*, TIME HEALTH (Sept. 27, 2016), http://time.com/4508369/why-u-s-women-still-die-during-childbirth/.

from its fee-for-service family planning program . . . ."[368] Some experts point to these changes as contributing factors to the increase in maternal fatalities.[369] Challenging the *Directives* in Texas may be a viable option to combat the rise in maternal death rates considering that at least one Texas appellate court has held a contract illegal when it had the potential to endanger public health and safety.[370]

If our three branches of the federal government truly want to protect the health and safety of women, a change must be made to increase access to reproductive services. This starts with judicial decisions barring Catholic hospitals from imposing religious views on third-party consumers. Clearly, the *Directives* have a direct impact on the health and safety of those governed by them. The many stories described in this comment show the physical and emotional suffering that stems from the *Directives*. Ultimately, if plaintiffs challenge these contractual provisions, courts can refuse to enforce them. Court refusals will slow the growth of hospitals governed by the *Directives* and bring necessary awareness to the impact these hospitals have on women's health. Awareness is important within our legal system because even if illegality is not pleaded as a defense, courts may have the power to invoke it.[371]

368. Amanda J. Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 347 NEW ENG. J. MED. 853, 858 (2016).

369. Sifferlin, *supra* note 367.

370. Merry Homes, Inc. v. Chi Hung Luu, 312 S.W.3d 938, 941, 946 (Tex. Ct. App. 2010) (holding a lease unenforceable for illegality, because the lease violated an ordinance that was intended to protect public health and safety).

371. Sinnar v. Le Roy, 270 P.2d 800, 801 (Wash. 1954) (holding that a court can render a contract void for illegality when such facts are present, even if no litigant is claiming illegality as a defense).

C. Balancing Individual Interests

Despite the strong arguments stated above, there must always be a balance when it comes to deciding between individual liberties. The Free Exercise Clause of the United States Constitution grants religious freedoms to citizens across the nation.[372] Furthermore, the Supreme Court has held that individuals have an absolute freedom of belief when it comes to religion.[373] However, the freedom to exercise that belief is subject to limitation "for the protection of society."[374] Adherence to religious *Directives* involves the physical well-being of much of society and presents the precise situation of religious exercise that puts people at risk. Public health and safety should be of the utmost concern to our public officials.[375]

Another place to look for guidance in determining the legality of a contract is to the people of the states.[376] Many citizens who identify as Catholic do not support Church interference in healthcare.[377] In fact, one study showed that 84 percent "of Catholic voters believe abortion should be legal in some or all circumstances."[378] In addition 77 percent of Catholic voters do not believe hospitals should be allowed to refuse certain procedures when receiving taxpayer dollars.[379] Moral behaviors and individual conscience are at the essence of Catholicism, and most Catholics believe that reproductive rights are something that is individual and unique to the person, not to be decided by Bishops.[380] Based on this data, even those the *Directives* are meant to serve disagree with their place in our healthcare system. This comment does not aim to criticize the Catholic religion or those who hold Catholic beliefs.

---

372. U.S. CONST. amend. I.

373. Cantwell v. Connecticut, 310 U.S. 296, 303 (1940).

374. *Id.* at 304.

375. *See generally* Thomas R. Frieden, *The Government's Role in Protecting Health and Safety*, 368 NEW ENG. J. MED. 1857 (2013).

376. Local No. 234 of United Ass'n of Journeymen v. Henley & Beckwith, Inc., 66 So. 2d 818, 821 (Fla. 1953) (holding that "courts have no right to ignore or set aside a public policy established by the legislature or the people.").

377. *See* HEALTH CARE COMPROMISED, *supra* note 28, at 17–18.

378. *Id.* at 19.

379. *Id.* at 18.

380. *See id.* at 17–18.

Instead, it is pointing out a religious abuse of power that is harmful to the reputation of the Catholic Church in general.

Provisions enforcing the *Directives* may be easily severed from the agreement if the contract contains a severability clause.[381] If no severability clause is present, courts may still severe the provision if it "does not defeat the primary purpose of the agreement."[382] Courts differ on whether or not they will sever a single provision at issue or the entire agreement.[383] In those states that do not allow for severability, more oversight from courts will likely be required. Nonetheless, because public health and safety are at issue here, this oversight appears necessary in the few courts where this could occur.

Considering contractual obligations have been held as unenforceable for far lesser reasons,[384] healthcare workers and consumers must start challenging these provisions as a matter of public policy and courts must hold them unenforceable. The United States is no longer dealing with sisters who embody the Catholic mission through charitable care. Instead, Catholic hospitals hide inexcusable patient care behind a shield of religion, while providing less for communities than their secular counterparts. When it comes to the health and safety of the people within the United States, individual human rights should prevail over institutional religion freedom.

V. CONCLUSION

Throughout the United States, there is a lack of respect for women's reproductive health. The Supreme Court, Congress, and the Executive Branch have all shown hesitancy to protect some of the most vulnerable women within our society. Many judicial decisions that have chipped away at reproductive rights over the years have not only defied well-established scientific research, but basic human reasoning. This

381. NANCY S. KIM, THE FUNDAMENTALS OF CONTRACT LAW AND CLAUSES 81 (2016).

382. *Id.* at 80 (citing Dawson v. Godammer, 722 N.W.2d 106, 110 (Wis. 2006)).

383. *Id.* at 80–81.

384. *See* Early v. MiMedx Grp., Inc., 768 S.E.2d 823, 828–29 (Ga. Ct. App. 2015) (explaining that a company contract with a consumer, requiring the employee to spend her working time solely on the customer's business, was an illegal restraint on trade).

comment only begins to list the effects that limiting these rights has on society as a whole and future effects remain unnerving. This stance of public policy is not based on a single tenuous argument. Instead, it concerns fundamental constitutional freedoms, criminal activity, the integrity of the United States healthcare system, rising healthcare costs, and the physical health and safety of women within our society. To deny these facts based on religious affiliation, is to look the other way.

*Brooke Raunig**

* J..D., *magna cum laude*, California Western School of Law, 2018; B.S.N, Chamberlain College of Nursing, 2015; A.S.N, Montana Tech of the University of Montana, 2012. I would like to thank Professor Nancy S. Kim for her continuous encouragement and guidance as both a professor and role model. I would also like to thank Professor Joana K. Sax for providing me with invaluable feedback and resources throughout the writing process. Finally, a special thanks to Lana Kizilarslan, Brittany Vojak, Madison Vojak, Erin Dimbleby, and Jonathan Scott for their constant support, feedback, patience, and inspiration.